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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

P.S.A. Lamek, Q.C.

E.A. Cronk

Thomas Millar

Commissioner

Counsel

Associate Counsel

Administrator

Transcript of evidence
for

September 27, 1983

VOLUME 40

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595-1065

Bedker (cont'd)

X Tobias

Shinley

Shine hope

Re: Scott

Cronk

Mancer

In chief PSH

X Scott

Cronk



ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Tuesday, the 27th
day of September, 1983.

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THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

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and 35 Registered Nurses at
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M. WHARTON Counsel for the Ontario
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W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child, Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child, Kevin Pacsai)



INDEX OF WITNESSES

<u>Name</u>	<u>Page No.</u>
<u>BECKER, (Dr.) Laurence Edward (Resumed)</u>	7928
Cross-Examination by Mr. Tobias	7928
Cross-Examination by Mr. Strathy	7950
Cross-Examination by Mr. Shinehoft	7971
Re-Examination by Mr. Scott	7987
Re-Direct Examination by Ms. Cronk	7994
Further Re-Examination by Mr. Scott	8036
<u>MANCER, James Frederick Kent (Sworn)</u>	8042
Direct Examination by Mr. Lamek	8042
Examination by Mr. Scott	8122
Cross-Examination by Ms. Chown	8160

INDEX OF EXHIBITS

<u>No.</u>	<u>Description</u>	<u>Page No.</u>
200	Excerpt from: "Editorial: The QT Interval and Sudden Infant Death Syndrome by Warren Guntheroth, M.D."	8017
201	Curriculum Vitae of Dr. James Frederic Kent Mancer.	8046
202A	Document dated August 24, 1982 re protocol for obtaining of samples re digoxin study.	8100
202B	Undated document re protocol for obtaining of samples re digoxin study.	8100



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---On commencing at 10:00 a.m.

MS. CRONK: I said we were ready, sir, but it appears that you and I are but the witness isn't quite here yet.

THE COMMISSIONER: Oh, all right. Mr. Tobias isn't here either.

MR. YOUNG: Mr. Commissioner, perhaps we can discuss the meeting that was to be held tomorrow evening.

THE COMMISSIONER: Yes.

MR. YOUNG: Mr. Brown is here and I'm here and you are here.

THE COMMISSIONER: Yes, that's all that matters, yes.

MR. YOUNG: I don't know if anyone else is here. I spoke with Mr. Percival yesterday and unfortunately he has commitments tomorrow afternoon and is not available. He has suggested the following Tuesday if that is agreeable to Mr. Brown's office and to you, Mr. Commissioner.

THE COMMISSIONER: Well, you can't tell me that.

MR. BROWN: Of course I can't tell you that, Mr. Commissioner.

THE COMMISSIONER: Well, I think you



1
2 had better check. It certainly wouldn't be possible
3 for me the rest of that week. The rest of that week
4 isn't much is it. The following Tuesday is possible
5 for me. Would you find out, Mr. Brown.

6 MR. BROWN: Yes, I certainly shall.

7 THE COMMISSIONER: And we will know
8 at noon and we can tell everybody what the story is.

9 MR. BROWN: Mr. Commissioner, I don't
10 think I can advise you by noon. Mr. Sopinka is out
11 of town. I can inform you of that tomorrow though.

12 THE COMMISSIONER: Oh, all right.
13 All right then we will resolve that problem tomorrow
14 morning.

15 MS. CRONK: I'm sorry, sir, we do
16 have Mr. Tobias as you can see but we are still
17 without a witness. I note that Mr. Ortved is not
18 here yet, if you would care to adjourn for five
19 minutes.

20 MR. TOBIAS: I was about to say,
21 Mr. Commissioner, given the impression that you seem
22 to have of me you probably have no doubt that I could
23 carry on for at least five or ten minutes without
24 the witness. Notwithstanding that I am complimented
25 by it, sir, I think Ms. Cronk's suggestion is an
excellent one.



1
2 THE COMMISSIONER: I tell you, there
3 is one problem though that I would like to take up
4 with you while we are waiting today and, that is,
5 I think you are a little too generous in letting
6 Mr. Strathy and Mr. Olah go after you. They are not
7 in the same interest and it might be wise to require
8 them to complete their examination before you complete
9 yours. I don't worry about Mr. Young, he's roughly
10 in the same interest that you're in but these others are
11 not and I'm not too sure - I don't want to have too
12 many people. I have started a system whereby the
13 solicitors for the clients will have their right to
14 reply but I don't want everybody having it and it
15 might be a thought anyway, I don't know where Mr.
16 Olah is this morning, he's not expecting to go on
17 right away.

18 MR. TOBIAS: I had given that some
19 consideration, Mr. Commissioner, over the course of
20 the evening break and what I thought I might request
21 of you this morning is simply this. I have but a
22 very few short questions remaining. Prior to Mr.
23 Ortved, Mr. Scott and Ms. Cronk commencing their
24 re-examination should I have anything arising out
25 of Mr. Strathy or Mr. Olah's cross-examination I
would like the opportunity at that point to re-examine.



1
2 THE COMMISSIONER: Well, there is
3 no question in fairness you should have it. The
4 only thing is I want to avoid this in the future.

5 MR. TOBIAS: Yes.

6 THE COMMISSIONER: So I say it is
7 all very well to defer to somebody in the same
8 interest but it is not all very well to defer to
9 somebody who has not the same interest because the
10 result of that is that we have -- however, as Mr.
11 Olah isn't here there isn't much I can do about re-
arranging things anyway. So, you carry on.

12 MR. TOBIAS: All right, thank you,
13 Mr. Commissioner. I see that during that exchange
14 Dr. Becker was good enough to get me off the hook,
15 so, it looks like I'm not going to have to cross-
examine without a witness.

16 DR. LAURENCE EDWARD BECKER, Resumed
17 CROSS-EXAMINATION BY MR. TOBIAS (Continued):

18 Q. Dr. Becker, I believe that
19 you in giving your evidence last Thursday to Miss
20 Cronk were asked some questions regarding the average
21 length of time that it takes to get a completed and
22 final autopsy report done and down to medical records
23 and into the hands of whoever they are going to. I
24 believe your evidence was that it can, and I am not
25



1
2 suggesting that you said that it does, but I
3 think you said that it can in some instances take
4 as long as two to six months, however, that would be
5 unusual. Is that a fair summary of what you said?

6 A. I believe I said it took
7 two to six months, yes, and then with respect to the
8 letter that Miss Cronk referred to with Miss Haffey's
9 signature I believe that was referring to the
10 preliminary report of four months and my comment with
11 respect to that was that it seemed like a somewhat
12 extended period of time.

13 Q. All right. You also gave
14 evidence, I believe I am summarizing it correctly,
15 that although that might seem like an extremely long
16 period of time given the manner in which pathology
17 departments worked and given your experience, and you
18 have been associated with a number of them, there was
19 nothing undue in that length of time?

20 A. That's correct.

21 Q. All right. Now, Doctor, if
22 in a particular instance it was simply not possible
23 to have an autopsy report, and I am talking now about
24 a final autopsy report, available six months after the
25 date of death, if it had to go several months longer,
let's say eight or nine months, would that be an



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2

extremely unusual situation?

3

A. I suspect it would be, yes.

4

Q. All right. In any event

5

however if whatever it was that you wanted to

6

investigate that required it to go several months

7

longer was well worthwhile in investigating, I take

8

it that you would accept that length of time; in other

9

words, you wouldn't be particularly alarmed or

10

concerned if it took eight or nine months to file

a final autopsy report?

11

A. I personally would be

12

concerned, yes. I would try to have the autopsy

report completed as soon as possible.

13

Q. All right.

14

A. I think you were referring

15

to the wider situation, the wider perspective of

16

what does happen.

17

Q. All right. What I am

18

specifically wondering about is this, Doctor. It

19

seems to me that specifically in the case of Jordan

20

Hines, from your own point of view and given your

21

own personal interest, it was a very important thing

22

to complete the microscopic study of the conduction

system?

23

A. From an academic point of

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view, yes.

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Q. Well, from an academic point of view and it was certainly a decision that you had made. You wanted it done and I believe you gave evidence that you intended to try and convince, I think it was Dr. Wilson.

A. Yes.

Q. Who was coming on staff in July of '81?

A. Yes.

Q. To attempt to do it?

A. Yes.

Q. All right. Under those circumstances why did you not wait until after July of 1981, after Dr. Wilson had started his study, to file a final report. Why was it necessary to file the final report immediately and prior to that extensive microscopic study being done?

A. I would not have waited until that study was done to file a final report in terms of investigating in a research way Sudden Infant Death Syndrome and various other things that we do and it doesn't necessarily mean that the final report is delayed. Those other things are in an academic or research category and they can go on for many



1
2 years. So, I wouldn't delay the report until those
3 other studies had been done.

4 Q. All right. So that what
5 you seem to be saying, Doctor, is that the final
6 report could have been filed in any event from the
7 point of view of completing your responsibilities
8 as staff pathologists and you could have then gone
9 on after the final report to pursue your academic
interest in the case?

10 A. Yes.

11 Q. All right. The other
12 question that I had was, given that scenario and
13 given that fact in keeping that specifically in mind,
14 why was it necessary at all to raise the academic
15 query in the final autopsy report. I take it that
it added nothing from a pathological point of view?

16 A. Very little but it is one
17 of my major interests, so, it was raised. That often
18 is done in the setting of an autopsy, that a report
19 in a hospital that there are academic questions
20 discussed in that report, it is not at all unusual.

21 Q. But you agree with me that
22 in terms of adding anything to your pathological
23 conclusions the academic query that you raised added
nothing?

24

25



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A. Oh, it is of interest,
certainly.

4

Q. Well, to who, Doctor?

5

A. It is of interest to me.

6

Q. Anyone else?

7

8

9

10

A. Well, I can't say if there
are other people interested in the SIDS problem,
Sudden Infant Death Syndrome problem reading the
report they would find that of interest to them
as well.

11

12

13

Q. But Doctor, you can
certainly see what I am concerned about and you can
see where my logic takes me. The report wasn't
being filed for you, was it?

14

15

A. Well, the report is signed
by me it is of some interest to me of course.

16

17

18

Q. Yes, but Doctor, isn't it
filed as part of your function as staff pathologist
at the Hospital?

19

20

21

22

23

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25

A. Part of my function as a
staff pathologist at the Hospital for Sick Children,
or any teaching hospital, is to be academic as well
and to discuss problems that are of academic interest.
It is not solely to record just the observations it
is to comment on them too.



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Q. In a case where death occurs under unexpected circumstances a post mortem is routine, is it not?

A. In which context? I would assume so, yes.

Q. You would assume so?

A. Yes.

Q. In fact if you don't get parental consent for post mortem in a situation where death is unusual or unexpected or happens suddenly, if the coroner has a particular interest in it he can require by law a post mortem?

A. If the death is sudden and unexpected, yes.

Q. All right. So, there is obviously some public interest in these cases in having a pathologist do an examination and file the report so that the public knows, and I use that in the broadest sense of the term, the authority, the state, call it whatever you want, so that the death is explained.

A. I understand that all of the records are of some interest, yes.

Q. All right. And isn't that really the key to what the pathology report really is?



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2

A. No.

3

Q. Isn't that its primary

4

function, Doctor. You certainly can't be sitting there

5

and telling me that its primary function is for the

6

pathologists to engage in his academic interest.

7

I just can't believe that that is your evidence.

8

A. Well, you will have to ask

9

other pathologists then in academic institutions in

10

terms of what their philosophy is in the autopsy

11

report. Certainly my philosophy is to discuss the

12

findings to the best of my ability and put them in

13

some academic perspective.

14

Q. All right. But Doctor,

15

right now I'm not examining other pathologists I'm

16

examining you. Is it your evidence that you think,

17

or that in your opinion - I'm not even going to ask

18

you to think - in your opinion are you stating that

19

one of the primary functions of that autopsy report

20

is to pursue your own academic interests?

21

A. Not my own academic interests

22

but to put my academic perspective - to put my

23

academic interest in the perspective of the case,

24

yes.

25

Q. All right. Leaving academics

aside, do you agree with me that in terms of



1
2 explaining the cause of death, academic aside, your
3 query added absolutely nothing to the information
4 contained in that report?

5 A. Oh, I think it is a very
6 important aspect of the case, I don't agree.

7 Q. Well, Doctor, with respect
8 listen to the question and answer only the question,
9 please, sir. I'm trying to get through this as
10 quickly as I can and save both you and I some time.

11 I said leaving aside your academic
12 interest, I am quite impressed that you think it is
13 of quite significant value, but leaving that aside,
14 from the point of view of coming up with an explanation
15 for that death, do you agree with the simple state-
16 ment that your academic query added nothing to
17 explaining the cause of death?

18 A. No, I disagree.

19 Q. Well, I won't pursue it.
20 Doctor, I take it that if I asked you what experience
21 you have had in interpreting digoxin readings -
22 well, I won't take it, let me ask it directly.
23 What experience have you had in interpreting digoxin
24 readings?

25 A. In what circumstances?
In the serum or in the tissues?



1

2

Q. In tissues.

3

A. Exhumed tissues?

4

Q. Post mortem tissue which
was preserved in clot solution.

5

6

A. I have had very little
experience.

7

Q. Have you had any experience?

8

9

A. Only subsequent to the
episodes that were subsequently - I mean only
subsequent to the episode we are concerned with.

10

11

Q. All right. Prior to that
you had had no experience, is that correct?

12

13

A. I can't be sure but I don't
recall any particular case that I was involved in,
no.

14

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Q. All right. Now, if you were
to be given test results, and I will be very very
specific, if you were to be given a digoxin level
that was obtained on post mortem heart tissue which
had been taken at autopsy five hours after death
which had been preserved for three months in clot
solution and which had been assayed three months
later and you were given the results of that assay,
you were given the reading, would you, on the basis
of your own expertise, not what someone else told



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you, all right, but on your own expertise, be able to tell us whether that result indicated that the findings placed the case in a toxic range or not?

A. No, I would not.

Q. So, in that respect you would have to defer then to the opinion of the various experts?

A. Well, I would have to take their opinion into consideration in terms of my own findings with respect to the cause of death, but in terms of the toxicity ---

Q. Doctor, I didn't ask you anything at all about the cause of death.

A. In terms of toxicity I would defer.

Q. You are anticipating me. I merely asked you a simple question and, that was, could you tell me if you had that information whether the reading placed that particular case in a toxic range or not?

A. No.

Q. And I thought your answer was no you couldn't?

A. That's correct.

Q. And all I have simply said



1

2

after that is, I take it therefore you would have
to defer on that specific example, on that peculiar
example, to the opinion of the various experts?

4

5

A. With respect to what though,
I'm not sure. I would have to defer to their opinion
with respect to what?

6

7

8

Q. Whether or not they found
the concentrations of digoxin in that tissue sample
in the toxic range?

9

10

A. Meaning...? Okay, yes.

11

12

Q. Are you having a great
deal of difficulty this morning in understanding
the questions. If you are please tell me and I
will try and make them easier for you.

13

14

A. Sometimes they are not
particularly clear, that's true.

15

16

17

Q. All right. Well, do you
understand the point that I am asking you now and
that simply is do you agree with me that you would
have to defer on that particular example to the
opinion of the various experts on the subject?

18

19

20

A. Yes, in terms of toxic
levels, yes.

21

22

23

Q. Okay, fine. Now, again,
if you looked down your microscope and the pathological

24

25



1
2 evidence indicated to you clearly and in uncertain
3 terms a finding of missed-Sudden Infant Death
4 Syndrome and on the other hand at the very same
5 time that you got that information you were given
6 the readings that I have just referred you to, that
7 is a particular reading at a particular level in
8 heart tissue that was taken at autopsy five hours
9 after death, fixed in clot solution and assayed some
10 three months later, would you be in a position, given
11 your knowledge of what that digoxin reading would
12 mean, to come to an opinion in your own mind regarding
not pathological diagnosis but what caused the death?

13 THE COMMISSIONER: I don't know
14 whether he can answer the question but I have some
15 trouble because the essential feature is is he using
16 his knowledge or is he using, is he deferring to the
17 expertise of some expert. That's the real problem.
18 He concedes he has no experience, I have no experience
19 at that time in interpreting digoxin post mortem
20 levels. So he can't do it. But the answer is so
21 obvious that I want to give it for him. The answer
22 would be that he would be in no position to do it
23 at that time without some expert assistance as to
24 the meaning of those digoxin levels.

25 Would you care to adopt that answer?



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THE WITNESS: I would agree with that,
yes.

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THE COMMISSIONER: Thank you.

5

6

MR. TOBIAS: I am grateful, Mr.
Commissioner. Thank you, I think you have saved me
a great deal of time.

7

THE COMMISSIONER: Yes, all right.

8

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MR. TOBIAS: Q. Now, Dr. Becker,
with respect to evidence that you gave again, I
believe it was on Thursday, did I understand you
correctly when you were asked by Ms. Cronk whether
certain physiological changes are set in or starts
setting into the various organs in the body after
periods of apnea one of the answers that you gave
was with respect to the brainstem scarring, the
brainstem gliosis, that that would take about two
weeks to show up?

17

A. Yes.

18

19

20

21

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23

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Q. Now, with respect to a
situation where there had been no apnea periods
during life whatsoever and instead of having a
missed-Sudden Infant Death Syndrome case we had a
case of SIDS directly, in other words no apnea
periods during life, just the one episode and the
child succumbed to the syndrome, would you also find



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brainstem scarring?

A. Well, you are making the
wrong assumption.

Q. Okay.

A. In Sudden Infant Death
Syndrome there may very well be apnea spells or
periods of hypoxemia but they are not recognized.
That is the essential difference. So that any
proportion of those children that have Sudden Infant
Death Syndrome there are certainly evidence of
astrogliosis, yes.

Q. All right. Now, let me
understand you. You are saying that is the essential
distinction between, in giving your label is what
you would call missed-Sudden Infant Death Syndrome
case and just Sudden Infant Death. Do I understand
that correctly?

A. Yes.

Q. All right. So that even
in a Sudden Infant Death Syndrome case there may have
been periods of apnea or hypoxia which were not
observed?

A. That's correct.

Q. All right. Now, if that
is so, then I take it that you would expect to find



1

2

brainstem scarring in the SIDS case?

3

A. In some cases of Sudden

4

Infant Death Syndrome, yes.

5

Q. Okay. Do you agree with

6

me that if there had been no prior periods of apnea

7

or hypoxia that you probably wouldn't find brainstem

8

scarring. Is that a correct assumption?

9

A. In a particular location

10

that is true. We must talk about a specific location.

11

I think I stressed that in the original testimony

and with that restriction that is true.

12

Q. All right, I understand

13

that.

14

A. To the best of my knowledge.

15

Q. What was the specific

location of the brainstem scarring of Jordan Hines?

16

A. Talking about particularly

17

the dorsal vagal nucleus which is the tenth cranial

18

nerve.

19

Q. All right. Now, does your

20

evidence hold with respect to that finding that it

would take two weeks for that scarring to show up?

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A. Astrogliosis takes two

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weeks to occur; some variability but as far as we

23

know it is approximately two weeks, yes.

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Q. But can it show up in one day?

A. No.

Q. That is not possible?

A. No.

Q. Why is that? Is that because it is a gradual process? Please explain it to me.

A. Well, different cells react within different periods of time and it happens that the astrocytes are cells that in order to show their glial fibrillary component to a sufficient degree takes two weeks.

Q. I understand that the first documented period of apnea in the Jordan Hines case was the period that occurred at home. Do you agree with that?

A. Yes.

Q. That is your interpretation of the medical chart as well?

A. Yes.

Q. I believe that was the spell that the mother described for the people at the North York General where the baby was in the basinettte and turned a bluish-gray colour and she had to pick him up?

A. Yes.



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Q. It is my information, Doctor,
that that happened on March 4?

4

A. Yes.

5

6

Q. Then there would have been
some periods of apnea following that on March 5th,
6th and 7th and the child died on March 8th?

7

A. Yes.

8

9

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11

12

Q. In order to support your
finding - not to support it, it was clearly there in
autopsy - there is no question there was brainstem
scarring, was that because there must have been apnea
at periods prior to March 4th?

13

A. Yes, there would have been,
but likely unrecognized.

14

15

16

Q. We obviously have no way of
knowing whether there in fact were or were not
because the child was not observed prior to March 4th?

17

A. Yes.

18

19

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Q. If, and I realize this is
hypothetical, Doctor, and I want to be fair in phrasing
the question, if we could somehow know that there were
no apnea periods prior to March 4, 1981, and I
realize that the reality is that we cannot know that,
but if we did now that, if that information was
available, would that cause you some concern in



1 explaining why there was brainstem gliosis?

2 A. I would explain it then on the
3 basis of events that occurred at the time of birth.
4 The fact that the child had a sub-ependimoe cyst next to
5 the ventricle suggests that everything was not normal
6 at the time of birth and at that time in fact there
7 may have been damage to that area of the brain and
8 the astrogliosis could have occurred then and
9 persisted to the time of death.

10 Q. Is it possible that given the
11 finding of that cyst that the damage could have
12 occurred at any time other than at birth. In other
13 words, if that is the explanation, then would that
14 have to have been an occurrence which happened at
15 birth or could it have happened in the weeks
16 following birth?

17 A. No, it would have had to have
18 occurred probably before birth because that area of
19 the brain is a transient area of cellularity which
20 essentially disappears as the 40 weeks gestation period
21 is reached.

22 Q. If that were the case, if in
23 fact it was something that happened at birth as a
24 result of the cyst --

25 A. Not as a result of the cyst.
The cyst only indicates that there was probably some
other thing going on in the child that we are not



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aware of.

Q. If we were to assume for the moment that that is what occurred, that it was damage at birth, and the cyst is an indication of that, would the brainstem scarring itself, taken as just one marker, still be suggestive of missed-Sudden Infant Death Syndrome?

A. Yes.

Q. So it really does not matter whether the damage occurred at birth, and the cyst is evidence of it, or whether it occurred because of the periods of apnea. In either case, the finding of brainstem scarring is suggestive to you of missed-Sudden Infant Death Syndrome. Have I that right?

A. The finding of scarring suggested that there is something wrong with the way the child is controlling his breathing mechanisms, and one manifestation of that is apnea. That apnea then is part of the diagnosis of missed-Sudden Infant Death Syndrome.

Q. Let me see if I've got it right at this point. The finding is suggestive that there is something wrong with the respiratory control and that in itself is indicative of, or a marker, of



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Sudden Infant Death Syndrome?

A. Yes.

Q. Fine.

Now, finally we come to the area that Miss Cronk was questioning you on on Thursday last when she asked you a series of questions regarding the possibility that a child had periods of apnea during life, observed periods of apnea, and was a candidate for missed-Sudden Infant Death Syndrome. However, before the child succumbed to the syndrome, as I recall her hypothetical question, the child was administered a massive overdose of digoxin.

Do you recall, generally, that question being asked?

A. Yes.

Q. I believe you indicated that one of these concerns that you had in analyzing that scenario is that you certainly could not ignore the pathological findings in a case like that, they would still be there, and the microscope - your pathological examination - would not give any indication of whether digoxin was or was not there. Is that correct?

A. Yes.

Q. I believe you also said, however,



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that you did not have too much experience with digoxin and you were not certain if indeed there were any pathological markers of digoxin toxicity?

A. To the best of my knowledge, there are no such markers.

Q. I believe exactly what you said was that you certainly had never heard of any. Is that correct?

A. Yes.

Q. Do you agree with me that, given the handicap, the obvious handicap that you are working from, that you really have no specific experience with digoxin, that if there were pathological markers you would not recognize them in any event?

A. That is correct.

Q. So, therefore, you cannot really say that the results of your pathological examination on any child would rule out digoxin toxicity because your state of knowledge does not permit you to come to that conclusion. Do you agree with that?

A. On the basis of pathology, that is correct.

MR. TOBIAS: Mr. Commissioner, those are all the questions I have for the witness. Thank



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you, Dr. Becker.

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THE COMMISSIONER: Thank you. Mr.

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Strathy.

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CROSS-EXAMINATION BY MR. STRATHY:

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Q. Doctor, I would like to change the subject and ask you some questions about the events that take place in a body after death. Let me begin by clarifying some terminology. We have talked about tissue. Can you tell us, please, what tissue is?

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A. Tissue is made up of cells, in a scientific way, but tissue is really - any organ would be tissue. In simple terms, any piece of human substance is tissue.

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Q. So the end of my little finger is a piece of tissue?

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A. Yes.

Q. When we talk of, as we have seen in some of these cases, heart tissue or liver tissue, it is simply a piece of the organ itself, is it?

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A. Yes.

Q. And it is made up, as you have told us, of cells?



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A. Yes.

Q. And I gather that during the individual's life it is a living entity?

A. Yes.

Q. How is the tissue kept alive? What keeps it alive?

A. It is important for the oxygen to be present to keep it alive plus the metabolites that are present in the circulating blood.

Q. I'm sorry --

A. The nutrients within the blood are important as well, in addition to the oxygen. The oxygen is probably the most important. It depends on the organ that you are talking about.

Q. Is it the blood that takes the oxygen to the tissues?

A. Yes.

Q. And the blood also takes the metabolites to the tissue?

A. Yes. It would take other nutrients, for example, glucose plus many other things.

Q. Is it the blood then that keeps the tissue alive?

A. Yes.

Q. Can you tell us what it is



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mechanically that takes place in the tissue after death?

A. After death, when a tissue is decomposing, the enzymes that are in the cells essentially self-digest the tissue. It is called autolysis and the tissue breaks down because of this enzyme activity. Then these enzymes that are released are also assisted by numerous bacteria. The bacteria from the gastro intestinal system overgrow and produce other enzymes and these further lead to destruction of the tissue.

Q. Just to go back a little bit, obviously the blood stops circulating at death?

A. Yes.

Q. And therefore the tissue - there is no nourishment to the tissue?

A. Yes.

Q. Is that when - immediately - that the enzymes start their work?

A. It is not really clear exactly when they begin but I would assume that they would begin very, very quickly after the blood stops, yes. For example, in the brain, that is certainly true.

Q. What about in tissues such as heart tissue?



Becker, cr.ex.
(Strathy)

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A. It is a little more difficult to be sure about the timing in the heart tissue but I would assume the same thing is occurring.

Q. Very soon after death that process starts?

A. Yes.

Q. Is it a process, literally, where the enzymes start to eat away at the tissue?

A. Yes.

Q. In lay terms, we could say the tissue breaks down, does it?

A. Yes.

Q. Is that a process that continues until there is no more tissue left?

A. Yes.

Q. Can you help us, just in general terms, with how long that would take, let us say, for a human heart to completely reach the stage where it is totally decomposed?

A. I'm sorry, I do not know.

Q. Would it be a matter of a number of years?

A. I would expect so, but I do not know.

Q. Then this bacterial process that



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you have described --

A. Yes.

Q. Is that the bacteria in the stomach?

A. In the lower bowel, yes.

Specific bacteria proliferate in the situation, special mains, largely putrefactive organisms.

Q. And those also start to eat away at the tissues, do they?

A. Yes.

Q. Would that start immediately on death?

A. No, that would take some time.

Q. How long after death would that process start?

A. It would likely start in a localized way within a week.

Q. That is localized to the stomach area?

A. Yes, that is correct.

Q. And then eventually, during the process of decomposition, would start to attack other organs?

A. Yes.

Q. Can you give us any indication



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as to how long after death the bacteria would start to work on the heart, for example?

A. It could work very quickly - probably also within a week. It could be earlier, depending on the composition of the bacteria in a particular individual's gastro intestinal system.

Q. Doctor, we have heard evidence from some pharmacologists about the way that digoxin works. As I understand it, the active force of the drug is concentrated in tissues, specifically heart tissues. Is that your understanding?

A. I'm not really an expert on digoxin or its localization, but I do understand that. That is about as far as it goes.

Q. Have I stated reasonably accurately your understanding, then?

A. Yes.

Q. Can you assist us, Doctor, as to what happens to a drug like digoxin in heart tissue after death?

A. No, I cannot help you.

Q. Do you know anything at all about the processes that take place after death insofar as drugs generally are concerned, in the



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body?

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A. No, I do not.

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Q. We have heard some evidence,

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and I'm sure we will hear some evidence down the line,

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as to what has been described as a multiplier effect

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after death with respect to digoxin. That is a

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notion that for some reason levels of digoxin in the

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blood are observed to multiply or increase after

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death as opposed to post mortem. Have you ever

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heard of that phenomenon?

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A. No, I'm not really familiar

with that area.

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Q. That is fair enough. We will

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leave that, then.

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Doctor, let me ask you about the

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effects on the body as you observe them, post mortem,

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of pre-mortem resuscitation efforts, and I'm sure you

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have had occasion to observe a number of autopsies

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where there have been pre-mortem resuscitation

efforts. Is that accurate?

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A. Yes.

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Q. First of all, could you tell us

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what the effects are on the body of cardio pulmonary

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resuscitation efforts insofar as you see them,

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post mortem?

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Becker, cr.ex.
(Strathy)

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A. Yes. There's going to be some variability in terms of - or a spectrum of things that one might see. Usually one does see needle puncture marks over the chest and maybe a small amount of blood associated with the needle puncture marks. There may be terminal congestion.

THE COMMISSIONER: I'm sorry, what do you mean by terminal congestion?

THE WITNESS: It means that the tissues may be a little fuller - they may have more fluid than they otherwise would have.

THE COMMISSIONER: Why do you say terminal?

THE WITNESS: Occurring with the resuscitation. Things stop circulating and the fluids collect.

Q. Are you talking there about any specific tissues?



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A. You may see a little extra fluid in the lungs, for example. The other extreme is if cardiopulmonary resuscitation isn't carried out carefully then there may be a lacerated liver, or a fractured rib or some other abnormality like that.

Q. I take it that occurs simply from excessive force being applied to the child?

A. Yes.

Q. And the needle puncture marks that you described, I take it those are from the intracardiac injection of medications in the course of the resuscitation?

A. Yes.

Q. Are there any other facts that you routinely see, or that you might expect to see, where there has been cardiopulmonary resuscitation?

A. There may be impressions where the electric shock had been given. You may have a slightly reddened area that would suggest that. Or the electrocardiogram, the little circular monitors that I used are sometimes still on the child, so there are things like that. Pathologically I don't think there is too much else.

Q. Do you ever see any form of bruising of the heart tissue, or effect on the heart specifically?



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A. I think you could see that, yes.

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Q. What is it that you observe? I

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have used my expression, perhaps you can tell us what
you ---

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A. Well, bruising is a good word.

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You might see a small amount of blood in the tissues
of the heart, yes.

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Q. Would I be correct in under-

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standing that the blood in the heart tissues that you
see is literally squeezed out of the heart by the
pressures that are applied?

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A. Well, likely some small, very

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small vessels that have ruptured, and you then get a
few red blood cells around those vessels. If numerous
small vessels have this type of rupture then you get
a small amount of blood and that would look like a
bruise.

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Q. Is that literally caused by the

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force applied to the heart?

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A. Probably.

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Q. Do you see any other type of

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damage to the heart?

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A. Not that I can recall.

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Q. Are you able to assist us at all

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as to what that bruising of the heart does to the

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drugs that may be in the heart tissues at the time
the CPR takes place?

A. No, I don't know.

Q. Now, the evidence of the
defibrillation efforts, or the electric shock efforts
that you see, I gather what we have been talking about
are external manifestations?

A. Yes.

Q. Do you see anything internally,
either microscopically or at gross autopsy, that
reflects those electric shock efforts?

A. Not as far as I know.

Q. Are you able to tell us whether
those electric shock efforts have any effects on
heart tissue?

A. No, I couldn't say that, I don't
know.

Q. May I assume you are not able
to assist us as to what, if anything, that electric
shock effort does to drugs in the heart?

A. Yes.

Q. Now you also mentioned the needle
puncture marks on the chest of the child. Would you
actually see puncture marks in the heart itself on
autopsy?



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A. You may, but it might be very difficult to see, but you may see them actually in the heart too, yes.

Q. And that is from the drug actually being injected into the heart?

A. That is correct.

Q. Does that injection of the drug into the heart, does that cause some form of damage to the heart?

A. Not as far as I know.

Q. Does that result in a release of any blood from the heart?

A. I would think very little. I assume that there was no release, we don't see any blood around the heart from that procedure as a general rule.

Q. Is the reason you don't usually see puncture marks is that they are simply so small they are not detectable?

A. That is likely so, yes.

Q. And are you able to assist us at all as to what the effect of those intracardiac injections is on drugs in the heart tissue?

A. No.

Q. Doctor, there has been some



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A. Yes.

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Q. Now is that taken from one of the chambers of the heart?

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A. It is usually taken from the venous side of the system. That is, it would be taken from the right or left atrium, but not necessarily so. Because, I think as I mentioned before it is sometimes difficult to get fluid blood at post mortem, so that various chambers of the heart may have to be sampled in order to obtain the blood.

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Q. But you actually do inject the needle into the chamber and withdraw blood?

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A. Yes.

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Q. And that is the usual place you go to?

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A. Yes.

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Q. Why is it difficult to take samples of blood at post mortem?

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A. Because at post mortem blood tends to clot.



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Q Clot?

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A. Clot.

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Q And how soon after death does
that clotting take place?

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A. It tends to be variable. It
probably begins very soon after death, but there is
a degree of variability from patient to patient, in
some the blood appears to be more liquid than in others.

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Q Is there any time frame you can
give us as to when it is absolutely impossible to
obtain a sample of blood?

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A. No, I really couldn't, usually
you are able to get some blood from somewhere. I
imagine with prolonged periods of time it would be
very difficult, within my experience it has always
been possible to get blood from somewhere.

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Q Apart from the heart, you
mentioned the dural sinus?

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A. Yes.

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Q Can you just point to the dural
sinus on your head?

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A. Just at the top of the head
here.

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Q The mid line down the head?

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A. Yes, that would be used



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particularly in younger children because the bones of the skull are not fused and therefore that venous sinus is sitting easily accessible to a needle and syringe.

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Q. That is a vein, is it?

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A. Yes, it is a large vein, the venous channel.

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Q. Is that the same as the sagittal sinus?

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A. Yes.

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Q. Doctor, there has been some evidence about a particular child where a sample was taken, a sample of blood taken post mortem and the leg was, we have heard, was squeezed so as to extract blood from a vein, is that a practice with which you are familiar?

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A. No, I don't think I have used that procedure.

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Q. Would you have any concerns about using that sort of procedure?

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A. Well, where would the needle be when you are doing that procedure? At the end of the blood vessel presumably?

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Q. As I understand it and, Doctor, I am just stating my lay understanding, the needle is



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taken in a vessel, a blood vessel, and some place in the leg and then the leg is literally squeezed or compressed so as to force blood down the vein.

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THE COMMISSIONER: I am not sure whether it is up or down. I may be wrong, I thought the squeezing was up, but maybe it was down?

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MR. STRATHY: We haven't actually heard the evidence of the individual who took the sample, Doctor, so I can't really assist you on the precise mechanics.

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THE WITNESS: I wouldn't see anything wrong with just squeezing the leg veins in obtaining blood if the needle were in the vein.

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MR. SCOTT: Is Mr. Strathy going to tell us - he has put a hypothetical question, is he going to tell us what the hypothetical is based on?

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THE COMMISSIONER: I think it is the Estrella case, is it not?

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MR. SCOTT: Yes. My understanding is that is not the way it happened in the Estrella case. If Mr. Strathy is going to get into it perhaps he can tell us ---

THE COMMISSIONER: Well, I don't think he's getting much help from the witness anyway. Are you going to press it?



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MR. STRATHY: No, I am not going to press it. Perhaps we should wait until we hear from the witness in the Estrella case.

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Q Doctor, there has been evidence with respect to samples of tissue placed in Klotz solution, is Klotz solution something you are familiar with?

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A In my experience I don't use it very much, but I know that it is used, particularly for preserving heart specimens.

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Q Heart specimens?

A Heart specimens, heart tissue.

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Q And what is Klotz solution?

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A Essentially it consists of Formalin, that is the major ingredient.

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THE COMMISSIONER: I am sorry, I missed that last part.

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THE WITNESS: Formalin, F-o-r-m-a-l-i-n, or methyleneglycol.

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MR. STRATHY: Q I'm sorry, I missed that last part, Doctor?

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A Formalin.

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Q Formalin and -- ?

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A Well, Formalin is actually methylene glycol.

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Q. Is that like formaldehyde?

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A. Yes.

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Q. That is a form of preservative, is it?

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A. Yes.

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Q. Let me ask you. You have told us that at autopsy you take routinely a number of tissue samples?

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A. Yes.

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Q. Are those samples placed in some sort of preservative?

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A. The preservative that is usually used is Formalin, yes.

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Q. Is that something you have on hand in your autopsy room I suppose?

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A. Yes.

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Q. Is it placed in Formalin immediately?

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A. As soon as possible, yes.

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Q. Is it a specific brand of Formalin, is it pure Formalin, what is it exactly that you at your Hospital place this tissue in?

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A. I think we use a 10 per cent to 15 per cent solution of formaldehyde, which is called Formalin.

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THE COMMISSIONER: I am sorry, I am a little confused. You said you don't use a Klotz solution much, is that a brand?

THE WITNESS: It takes another substance, the name of which I can't remember, which is used, which is put into the Formalin because it helps to preserve the colour better.

THE COMMISSIONER: I see, but you use preservatives though all the time?

THE WITNESS: Oh yes, preservatives are always used, yes.

MR. STRATHY: Q. Well, the sample - I am just simply trying to clarify it from a technical point of view, Doctor, what exactly you put this tissue in? Is there some way you can describe it that will make us absolutely sure of what it is, is there a trade name?

A. I think the best thing is to think of it as formaldehyde.

Q. So you get formaldehyde from some supplier?

A. Yes.

Q. And you dilute it to 10 per cent or 15 per cent?

A. Yes.



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Q. What do you dilute it with?

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A. Water.

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Q. And then you simply use that as
your preservative?

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A. Yes.

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Q. There is nothing else that goes
into it?

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A. Well, there are some other
components to the solution. In other words, because
the Formalin tends to be fairly acid we put in other
things to make it less acid, but the exact composition
of those other things I would have to find out for you.

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MR. STRATHY: I am not sure at this
stage, Mr. Commissioner, whether that is necessary,
but if it is necessary perhaps I can address inquiries
at some future date to Mr. Scott.

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THE COMMISSIONER: Mr. Scott, yes. I
am trying to do my best to keep witnesses from
coming back, notwithstanding all Mr. Lamek's plots,
but sometimes I won't be successful.

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MR. STRATHY: I will do my best to
assist you then.

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Q. Doctor, just to be clear though,
Klotz solution has a separate and distinct meaning to
you?

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A. Yes, because it is Formalin but in addition there is another component which is put into the Formalin to preserve the colour of the tissue.

Q. Is that something that you use in your Hospital?

A. Yes, it is used for heart tissue.

Q. When we are looking at heart tissue from your autopsies --

A. Yes.

Q. -- and let us deal specifically with the autopsies of the children that we are concerned with in these proceedings.

A. Yes.

Q. May we take it that those tissues were in fact preserved in Klotz solution?

A. Yes.

Q. And is that from some specific supplier, do you know?

A. I don't have the information on that.

MR. STRATHY: Again we will leave that and if it appears necessary in the future -- thank you.

THE COMMISSIONER: Thank you, Mr. Strathy. Mr. Young?

MR. YOUNG: We have no questions.



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THE COMMISSIONER: Mr. Arnold?

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MR. ARNOLD: Mr. Olah has no questions.

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THE COMMISSIONER: Mr. Shinehoft?

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CROSS-EXAMINATION BY MR. SHINEHOFT:

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Q Doctor, would you define your
role as a pathologist as somewhat different from that
of a clinician?

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A Yes.

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Q And I believe at the beginning
of your evidence you talked about, a bit about your
role as a pathologist, but perhaps you could just
redefine that for us?

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A A pathologist is concerned with
the structural biology of disease, to a certain
extent the functional aspects of that biology,
which means he uses primarily as tools a microscopie.
So he is using either a conventional microscope or
an electron microscopie, those are the tools a
pathologist uses, and what he is doing is looking
at the tissues.

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Q You have stated on several
occasions, Doctor, that you couldn't give any kind
of any opinion as to a clinical diagnosis because
that is not your area of expertise, is that right?

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A. Yes. What we do at pathology is try to take the clinical diagnosis into consideration in reaching a pathological diagnosis but we are not seeing live patients, so, we are not making clinical diagnoses.

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Q. Right. Would the opposite be true to a certain extent, or to a large extent, that a clinician would be somewhat incapable of making the analyses that you make because they are not trained in the special areas that you are?

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A. Yes, I think that would be fair.

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Q. What happens, Doctor, where a person has an electrical problem with their heart; for example, they have no clinical abnormalities or no clinical diagnosis other than perhaps a tachycardia or a bradycardia and that person dies and you are performing an autopsy. If I give you a hypothetical. Suppose on autopsy the structures of the body, and mainly the heart, are absolutely normal, what would you do after that?

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A. You mean there is nothing in the clinical story and at pathology there are absolutely no findings whatsoever?

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Q. Right, what happens then?

A. It is certainly an unusual -



Becker, cr.ex.
(Shinehoft)

D-2

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2 I suspect if nothing was found then the Coroner
3 would be called.

4 Q. Well, have you ever had that
5 situation, for example, where a baby has been
6 admitted to hospital with perhaps an electrical
7 problem and the baby subsequently dies, you do an
8 autopsy and there is no abnormalities that you find
9 on autopsy, on gross autopsy, what would you do?

10 A. An electrical problem is
11 present?

12 Q. Perhaps. You made reference
13 I believe yesterday or the day before to sick
14 sinus syndrome.

15 A. Well, if there was only an
16 electrical aspect present and the pathology was
17 normal one might want to examine the conduction
18 system in that situation and one might also - well,
19 I think it would be primarily the conduction system
20 one would be concerned with if there was nothing
21 else elsewhere. But even on examining that
22 conduction system morphologically we may find nothing
23 because the abnormality may be chemical or
24 electrical.

25 Q. Well, just to discuss for a
moment Jordan Hines. You have been introduced to



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Exhibit No. 150 I believe, which is the Coroner's report. In his cause of death I believe he refers to sick sinus syndrome, is that correct?

A. Yes, I believe that was on the report.

Q. My question is Doctor, how could he or any other doctor come to that conclusion?

A. I don't know how that conclusion could be reached on the basis of pathological findings. It is basically an electrical diagnosis.

Q. Well, you mean you have never given a cause of death in the thousand autopsies that you have performed of sick sinus syndrome?

A. No.

Q. And you are saying that to have that diagnosis requires a study of the conduction system of the body, is that correct?

A. Even if the conduction system of the body had been done in sick sinus syndrome you wouldn't find anything there.

Q. Okay. Well, I understand that qualification but even if, to get to the first stage, you would have to have a conduction study



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performed. Is that correct?

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A. In order to do what?

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Q. In order to perhaps come to the conclusion that a particular child died of sick sinus syndrome?

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A. I don't think there is any pathology been reported with sick sinus syndrome.

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Q. Well, my question again, and I don't want to repeat myself, Doctor, is how would any doctor, coroner or pathologist or clinician come to a conclusion that a particular baby died of this particular problem?

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A. I think a clinician could make---

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MR. HUNT: I wonder if I could interject here, Mr. Commissioner. This exhibit that my friend is referring to, which is part of Exhibit 150 is the Coroner's investigation statement dated April 7th for Jordan Hines. Now, this has gone in along with other exhibits and of course the danger is that it is going to be treated as it is apparently by my friend as if this was a final report by the Coroner. Until Dr. Teperman testifies and explains the nature of the investigation statements that he signed on April 7th, the true purpose and nature of it is not going to come out.



Becker, cr.ex.
(Shinehoft)

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2 But I think I can indicate at this
3 point that I expect at that time that you will hear
4 on the 7th of April, which was shortly after the
5 investigation began, Dr. Teperman opened files on
6 a number of cases, this case being one of them and
7 the reference to sick sinus syndrome, far from
8 being a final cause of death in the opinion of Dr.
9 Teperman, is taken from the official diagnosis
10 that was made on Jordan Hines when he was referred
11 to the Hospital for Sick Children and in his
12 report he goes on to say, call it by what means,
13 he notes, further investigation by Metro
14 Homicide, so, this report ought not to be treated
15 by my friend or indeed by anyone as if this was a
16 final determination by Dr. Teperman based on all
17 the evidence as to the cause of death.

18 THE COMMISSIONER: Well, two things.
19 Before you answer that, Mr. Shinehoft there are two
20 things. First of all, this is not the witness to
21 ask about that, Dr. Teperman is the one to ask and
22 secondly, I don't know what this has to do with
23 Kevin Pacsai.

24 MR. SHINEHOFT: Well, I just wanted
25 to discuss - well, there is a reference to the
condition of sick sinus syndrome in the preliminary---



Becker, cr.ex.
(Shinehoft)

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THE COMMISSIONER: Well, I know,
but what is the diagnosis of Jordan Hines, sick
sinus syndrome, got to do with Kevin Pacsai?

MR. SHINEHOFT: Well, I'm not
referring specifically to Jordan Hines.

THE COMMISSIONER: Can I just put
the question to you.

MR. SHINEHOFT: All right. I'm just
asking the doctor the question in the abstract as
to what pathological findings might one expect, if
any, with a child with that particular condition.

THE COMMISSIONER: Well, Ms. Cronk,
you have it.

MS. CRONK: Thank you. I don't like
to interrupt Mr. Shinehoft but in response to the
remarks made by my friend Mr. Hunt I can only say
that if Mr. Hunt is aware of any additional
supplemental or final reports done by the Coroner's
Offices other than the ones that have been filed
with respect to Jordan Hines, Commission Counsel
would be most pleased to see it.

MR. HUNT: Well, that may be. If
my friend is suggesting that this was intended to
be a final report she is in error and if there are
others - and there may not be.



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THE COMMISSIONER: Well, there is a Coroner's report on Jordan Hines.

MS. CRONK: That's the one to which my friend Mr. Hunt is referring and I'm not taking it any further than he is suggesting but I thought he was saying there was yet another.

THE COMMISSIONER: What exhibit is that, please?

MR. HUNT: This is part of Exhibit 150, which is, as you may recall we have given with a number of Coroner's investigation statements.

THE COMMISSIONER: Yes, all right.

MR. HUNT: And with respect to this one, as I indicated, this is one prepared on the 7th, which was the date on which a number of files were officially opened by Dr. Teperman and that's all this is.

THE COMMISSIONER: Well, you have heard Miss Cronk, if you are aware of anything further done we should have it.

MR. HUNT: Yes, all right. Now, Mr. Shinehoft, just bearing in mind the two problems I have. One is you are representing Kevin Pacsai and the second one is that this is not the diagnoser of sick sinus syndrome, that was someone else.



1 MR. SHINEHOFT: I am interested in
2 the pathology of sick sinus syndrome.

3 THE COMMISSIONER: All right, but
4 he has told you that there is none.

5 MR. SHINEHOFT: Q. That is correct,
6 Doctor?

7 A. The only type of pathology that
8 would be present to my knowledge is that there might
9 be a viral myocarditis that could in turn produce
10 a sick sinus syndrome but that isn't the pathology
11 really of the sick sinus syndrome per se.

12 Q. Thank you, Doctor. We have
13 seen, Doctor, that on a number of occasions where
14 the clinicians have given a possible cause of death
15 and when in fact the autopsy is performed it hasn't
16 been as they have suggested. A couple of examples
17 was what you have just mentioned with the Baby Hines
18 this viral myocarditis infection or a virus which
19 on autopsy it was not found to be, is that correct?

20 A. Yes.

21 Q. Do you recall that?

22 A. Yes.

23 Q. And there is another baby, and
24 I don't know if you were involved with this baby,
25 where the baby had a shunt which they thought had
occluded and on autopsy it was shown that the shunt



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had not in fact occluded. Are you aware of that

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as well?

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A. No, I'm not aware of that case.

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Q. Has it happened, and perhaps you could give me some idea as to how often it would happen where the clinician gives a possible cause of death and in fact when the autopsy is performed that that is not shown to be the cause of death?

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A. I can't give you any statistics on that but of course that is the reason we do the autopsies.

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Q. It is in fact to confirm the so-called clinical diagnosis of death.

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MR. SHINEHOFT: Q. But that is one of the reasons, is it not?

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A. Yes.

Q. And does it happen on a fairly regular basis. You have indicated that you performed over a thousand autopsies? What the clinician has thought to be the cause of death has in fact turned out to be another cause of death?

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A. I have not looked at them



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2 statistically. I can't give you any definite
3 figures on that.

4 Q. So, you don't know if it is
5 five per cent or ten per cent or 20 per cent?

6 A. No, I wouldn't want to hazard
7 a percentage figure on that.

8 Q. But it does happen?

9 A. Certainly it happens, yes.

10 Q. And I believe you said that
11 before you do the autopsy you examine the medical
12 records of the particular patient?

13 A. Yes. I said that the resident
14 involved in the case in a hospital autopsy would be
15 involved in looking at the medical records, yes.

16 Q. And that is one of the
17 determinants in assisting you in coming to the
18 conclusions that you do?

19 A. Well, it would guide us in terms
20 of the type of differential diagnosis that we would
21 consider before doing the autopsy, yes.

22 Q. Now, it is possible I imagine
23 for clinicians to look at various findings, various
24 medical charts and reports and give a possible cause
25 of death for a particular patient, is that correct?

26 A. For a clinician to do that?



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Q. Yes.

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A. Yes.

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Q. And would it be possible for a
clinician to do this, say, a year or two after the
particular child's death?

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A. I would think so, yes.

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Q. And would the passage of time
have anything to do with the opinion rendered by a
particular clinician?

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THE COMMISSIONER: Might have
forgotten I suppose.

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THE WITNESS: I suppose, I really
don't know.

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MR. SHINEHOFT: Q. Well, let me
ask you this. Would you find it unusual if an
autopsy were performed and a diagnosis given as to
the cause of death and a clinician a year or two
later reviewing the charts came to a totally different
conclusion as to the cause of death, would that
surprise you, Doctor?

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A. I'm not sure what the
circumstances, what his background is. There are so
many variables in the question it is hard for me to
give a very accurate answer.

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Q. Well, I think you have said your



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area of expertise is one of trying to determine the cause of death?

A. That's one aspect I'm concerned with, yes.

Q. And would you feel that you're better qualified or able because of your particular education and expertise to do that as opposed to a clinician?

A. No, it depends on the circumstances in the case and we may very well have to rely on clinical information. I don't think it is as cut and dry as that.

Q. I see. Can there be in fact multiple causes of death?

A. There may be a variety of factors that come into play in terms of the final event.

Q. But I understand that it is your desire to narrow it down to one particular cause of death?

A. It's not always possible to do that. I think I mentioned many times in pathology we are interested in the diagnosis and we're interested in explaining to the best of our ability the mechanism of death, the cause of death, but there may



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be a variety of factors that come into play.

Q. And have you in fact in the reports that you have compiled given multiple causes of death or multiple possibilities as to the cause of death of a particular patient?

A. I don't recall specifically such a situation but it is possible.

Q. So, is it fair to say that normally you would have one cause of death?

A. No, it is not as simple as that because there are a variety of factors that come into play and we may in a report mention these various factors.

Q. But in the end you normally say one particular thing was the major cause of this person's death?

A. One tries to do that.

Q. And I believe in response to a question asked by Mr. Strathy you were asked about bruising on the heart on autopsy and you said that it is possible to see that. How often would you have seen that?

A. I can't give you an accurate figure in terms of percentage.

Q. Would it be somewhat infrequent?



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A. I really don't think it is infrequent but I can't give you a very accurate or apprehensive answer.

Q. Have you ever heard of a condition, Doctor, called transient hypofunction of the adrenal cortex?

A. I don't recall having heard of that.

Q. And would that be an area of expertise for an endocrinologist?

A. It probably would be more in line with that or with a pathologist who had a particular interest along those lines.

Q. And is there a pathologist at your hospital that has a particular expertise in the area of the adrenal glands?

A. I think some of our other pathologists would be able to answer that question better, yes.

Q. And who might be - do you know the names of any particular pathologists at the Hospital who would have that area of expertise?

A. Well, I'm not sure if it is an area of expertise but I know some of the members, for example, Dr. Mancer has written on this subject but I



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don't know if he's familiar with that particular area.

Q. Okay. You are saying, Doctor, that you have never heard of this condition or you have heard of it but ---

A. I can't recall having heard of it.

Q. You can't recall?

A. I can't recall.

Q. Are there various types of conduction studies of the heart that are available or is there just this one study that you have mentioned the other day that requires approximately 10,000 slides and costs thousands of dollars to perform?

A. No, there are compromises that can be used.

Q. And have they in fact been used at the Hospital before - I forget the name of the doctor who is now on staff.

A. I don't believe so but I couldn't be absolutely sure.

MR. SHINEHOFT: Those are all the questions I have, thank you, Dr. Becker.

THE COMMISSIONER: Yes, thank you.



1 Mr. Scott?

2 RE-EXAMINATION BY MR. SCOTT:

3 Q. Dr. Becker, I think you
4 described your analysis of the Hines baby as
5 pathologically revealing a classic case of SIDS. Do
6 I have that right?

7 A. The pathology was characteristic
8 of Sudden Infant Death Syndrome.

9 Q. And it was I think in a phrase
10 you used earlier classic?

11 A. Yes.

12 Q. Yes. Now, I take it that, and
13 perhaps you covered some of this with Mr. Roland, but
14 I just want to make clear that your particular
15 interest is in the neuro pathological origins of SIDS?

16 A. Yes.

17 Q. Yes. And you are for the moment
18 accepting in your study the theory of neurological
19 triggering of the apneic spells which results in
20 SIDS, the infant death?

21 A. Yes.,

22 Q. Yes. And you believed Baby
23 Hines to be a classic example of that?

24 A. Yes.

25 Q. Yes. Nonetheless, the baby



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exhibited arrhythmias?

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A. In the sense of bradycardia and tachycardia, yes.

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Q. Yes. And I take it that your interest in the case was that you hoped to show to yourself and other scholars that arrhythmias, though rarely demonstrated, were of neurological origin?

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A. Yes.

Q. Yes. And that to do this you had to satisfy yourself and other scholars that the arrhythmias did not originate morphologically, that is, from the heart?

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A. Yes.

Q. Yes. And I take it that it was to exclude that as a scientific matter that you had to persuade someone, namely, Dr. Wilson, to do a conduction study?

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A. Yes.

Q. Yes.

A. That would have been the situation.

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Q. And therefore the purpose of this conduction study was to exclude or to demonstrate that these arrhythmias were not morphological but were rather neurological?



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A. That they were not morpho-
logical in the heart but had originated from
abnormalities in the brain, yes.

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Q. Yes. And that if those studies
had been done that would have been, or might have
been a useful contribution to academic understanding
of SIDS?

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A. Certainly.
Q. Yes. Now, one of the counsel
asked you, it was touched on once or twice, why the
Hines baby would not be discussed or was not
discussed at the weekly pathology meeting, and I
take it that in the ordinary course a baby would not
be discussed at the weekly pathology meeting until
the microscopy studies were back?

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A. Not necessarily. In this case
of Jordan Hines it would have been important to have
the microscopic sections back so that we could make
sure that we had the correct diagnosis, but in other
events, in other situations it might be different.

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Q. Well, I am speaking too
generally then. Would it be correct to say that
there would be no particular point in discussing the
Hines baby at a weekly pathology conference until you
had the microscopy studies back?



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A. Yes.

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Q. And I take it that they
arrived back on March 23rd?

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A. Yes, the brain sections would
have been back by then.

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Q. And they came back because the
Metropolitan Toronto Police asked that they be
brought back as an urgent matter.

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A. Well, my understanding was that
they were involved in suggesting that we speed up
the autopsies, yes.

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Q. And does that explain why there
was no weekly pathology meeting that discussed the
Hines baby before March 23rd?

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A. Yes, it could explain that.

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Q. Yes. Is there any other
explanation that occurs to you?

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A. The other explanation that I mentioned before was that I do not think that Dr. Gillan was particularly interested in Sudden Infant Death Syndrome and he would likely not have been anxious to put that on the list.

Q. Let me ask you this. Apart from the microscopy studies which were not available until March 23 was there anything of academic or research interest in this classic case of SIDS that the Baby Hines represented?

A. No, at that point we did not have a definite diagnosis, that is correct.

Q. All right. Let me just follow up that.

I take it that you therefore did not have a definite diagnosis until the microscopy studies were back?

A. That is correct.

Q. That came back, you have told us, on March 23rd?

A. Yes.

Q. Mr. and Mrs. Hines, and one well understands their concern and unhappiness at these tragic events, have made complaints that they did not receive any information as to how their



1
2 baby died. Do I understand that it was not possible
3 to give them any information pathologically before
4 March 23rd?

5 A. Yes, that is correct.

6 Q. And on March 23rd you
7 delivered the autopsy report in final form to the
8 Metropolitan Toronto Police?

9 A. I do not know when that
10 occurred.

11 THE COMMISSIONER: I do not think
12 that is - the 23rd was probably the date - was the
13 date on it?

14 MS. CRONK: It is the 25th, Mr.
15 Commissioner.

16 THE COMMISSIONER: The 25th, yes.

17 MR. SCOTT: Q. All right. Were
18 you aware whether any instructions had been given
19 as to public disclosure of information after the
20 Metropolitan Toronto Police arrived?

21 A. I cannot recollect any
22 specific conversation or meeting but my impression
23 was that the information was to be kept confidential
24 during that week, yes.

25 Q. Now, you were read your
examination by one counsel at Volume 39, page 7751



in which you were asked by Mr. Hunt:

"Q. So that insofar as the cause of death is concerned you would be quite prepared to change your opinion based on other evidence that may or may not be presented.

A. In terms of cause of death rather than diagnosis.

Q. In terms of cause of death?

A. Yes; a pathology I couldn't say in terms of.

MR. HUNT: Okay, thank you."

Has any other information been presented to you at this Inquiry or anywhere else which changes your pathological determination?

A. No.

Q. Do you know the name Alexander Nadas?

A. No.

Q. Have you ever heard of the Boston Children's Hospital?

A. Yes.

Q. Let me tell you that Dr. Nadas is a cardiologist at that hospital.

Were you aware that Dr. Nadas had



1
2 classified the death of the baby, Jordan Hines, as
3 expected and consistent with the clinical symptoms?

4 A. I am not sure if I was or
5 not.

6 MR. SCOTT: Those are all the
7 questions I have. Thank you, Dr. Becker.

8 THE COMMISSIONER: All right. Ms.
9 Chown.

10 MS. CHOWN: No questions, Mr.
11 Commissioner.

12 THE COMMISSIONER: Miss Cronk.

13 RE-DIRECT EXAMINATION BY MS. CRONK:

14 Q. Dr. Becker, just a few
15 questions, if I may.

16 Following up first on the question
17 that was just put to you by Mr. Scott you will recall
18 that he asked you whether or not any information had
19 come to light since the date of the autopsy report
20 on Jordan Hines which had led you to change what
21 he referred to as your pathological determination
22 in that case. I believe your answer was no.

23 A. Yes.

24 Q. Do I take it correctly,
25 Dr. Becker, that you were referring in that regard
to your terminal diagnosis of missed-SIDS?



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A. The terminal diagnosis, yes, stands. No, I thought that assumed we were talking about the cause of death.

Q. I have it then that in terms of the terminal diagnosis, as you have told us previously, that that stands?

A. Yes.

Q. And there has been no information brought forward which would warrant or prompt you to change that. Do I have that?

A. Yes.

Q. In respect of your understanding as to the cause of this child's death, I take it you have now told Mr. Scott that there is no information of which you are aware that would cause you to question that further than you had done so in respect of preparing the autopsy?

THE COMMISSIONER: I may be wrong, I thought he said that there was nothing to change the diagnosis but there may well be, if the digoxin levels are --

MS. CRONK: That is why I would like to be clear, Mr. Commissioner, because it was the phraseology of "pathological determination" that perhaps suggested a new entrant.



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MR. SCOTT: Pathological was not a pejorative expression referring to the determination as in that I might make a pathological determination, but it was referring to the science. I asked him if there was any evidence that altered that.

THE COMMISSIONER: And there isn't.

MR. SCOTT: And he said no, and there is not, yet.

THE COMMISSIONER: No, there is not yet, but there might be evidence which would change his opinion of the cause of death but there is not any evidence that would change his opinion of the pathological diagnosis of the child.

MS. CRONK: That is my point, Mr. Commissioner. It was the word "determination" when Dr. Becker responded to it, did he take that to mean diagnosis. Do you have any difficulty with the way the Commissioner has expressed what was said?

THE WITNESS: No.

MS. CRONK: Thank you.

MR. SCOTT: Mr. Commissioner, if there is any evidence that the Commission seeks to put forward that may alter the opinion, should it not fairly be put to the witness?

THE COMMISSIONER: Presumably all



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2 the evidence is the digoxin level readings, post
3 mortem.

7 4 MR. SCOTT: Surely if my friend
5 wants to pursue that, if she has some evidence
6 on that score, she should put that to the witness.

7 MS. CRONK: I did, in chief, Mr.
8 Commissioner, and it was done twice in cross-examination.

9 THE COMMISSIONER: I do not think
10 there is any question, it has been put to the witness
11 and he has said that he is no expert on it. He does
12 not know what it means and he is waiting for the final
13 decision of the various conflicts that the
14 pharmacologists are having and I guess we will just
15 all have to be patient, too.

16 MS. CRONK: With that speedy start,
17 Mr. Commissioner, if I might continue then with Dr.
18 Becker, I think I understand the exchange now.

19 FURTHER RE-DIRECT EXAMINATION BY MS. CRONK:

20 Q. You recall that in the course
21 of your examination by Mr. Roland yesterday that
22 you told him, as I understood it, that as a result
23 of your special interest in SIDS cases that you are
24 personally involved in virtually in all of the
25 autopsies conducted at the Hospital for Sick Children
on SIDS victims or, alternatively, where you were



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2 not personally involved you became aware, in virtually
3 all of those cases, of the results that had been
4 obtained at post mortem.

5 Do you recall that evidence?

6 A. I would be aware of the cases
7 in the sense that I would be looking at the nerve
8 tissue, or the brain tissue, from those cases, yes.

9 Q. I take it you do that as
10 part of your ongoing research into SIDS?

11 A. Yes.

12 Q. You told me in chief and
13 again told Mr. Roland, as I understood it, during
14 his examination, that in the 10 year period from
15 1973 through to 1982 that there were 421 autopsies
16 at the Hospital for Sick Children in respect of
17 infants whose deaths were attributed to SIDS.

18 Do you recall that?

19 A. Yes.

20 Q. And of those 421 you
21 indicated again, both in chief and to Mr. Roland, that
22 there were 24 of those where the deaths had actually
23 taken place at the Hospital for Sick Children. Do
24 I have that correctly?

25 A. Yes.

Q. As Mr. Roland suggested,



1
2 that leaves us with approximately 397 cases where
3 the children's deaths were attributed, on autopsy,
4 to SIDS or missed-SIDS, but they died elsewhere than
5 at the Hospital for Sick Children. Do I have that
6 correctly?

7 A. Yes.

8 Q. Of those 397 cases, Doctor,
9 do you know, based on the statistics that you have
10 and your interest in those cases, how many of those
11 deaths occurred at home as opposed to in a hospital
12 setting?

13 A. I am sorry, I do not have
14 that information.

15 Q. It has been suggested by
16 a number of other witnesses, Dr. Becker, that in
17 most instances most SIDS deaths occur in the home.
18 Is that an observation with which you would agree?

19 A. Yes.

20 Q. I take it we can agree that
21 that is likely the result, regrettably, result of the
22 lack of sophisticated monitoring equipment that is
23 available in the home?

24 A. Yes, although that is
25 changing, I should add because with the better
resuscitation a lot of these children are now being



Becker, re.dr.
(Cronk)

1
10 2 brought to hospitals and resuscitation attempts are
3 being more successful, so there might be a change
4 with time, in other words, results might be better
5 now than they were 10 years ago.

6 Q. But for the moment, unless
7 the parents have monitoring set-ups in their own
8 home or have been trained to personally observe the
9 conditions that require resuscitation, we are con-
10 fronted with the situation where most of those deaths
11 still continue to occur in the home?

12 A. Yes, that is right.

13 Q. One of the concerns, I
14 take it, of the modern paediatric hospital with the
15 degree of sophistication and expertise of your own,
16 is that when an infant with a apneic history is
17 admitted to the hospital the hospital is concerned
18 to take whatever preventative measures might be
19 available to it to avoid either a recurrence of
20 another apneic episode or, alternatively, if one were
21 to occur, a tragic or terminal result from that
22 episode. The hospital is obviously interested in
23 doing that?

24 A. Yes.

25 Q. There are various methods,
I take it we can agree, available in a hospital such



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as your own to encourage that preventative posture,
the first being the provision of the kind of monitors
you have just referred to, that is both cardiac and
apnea monitors. They are available for that purpose?

A. Yes.

Q. In addition, nursing care
might be intensified to permit closer human monitoring
as opposed to monitoring afforded by the hardware,
the technology in the hospital?

A. I would assume so, yes.

Q. In addition, depending on
the severity of the case, the child might be admitted
to a ward which, by its concept and purpose, permitted
closer human monitoring. I have in mind the Intensive
Care Unit or a Neonatal Care Ward. That is also
possible.

A. It is certainly possible,
yes.

Q. And it is also possible, I
take it we can agree, that vital signs might be
measured more frequently than they perhaps otherwise
would in an effort to keep open the possibility for
close human monitoring of children known to have that
kind of history?

A. These are really questions



Becker, re.dr.
(Cronk)

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2 that probably should be put to a clinician, but I
3 would assume so, yes.

4 Q. Thank you Doctor.

5 Of those 397 cases that you have
6 described as having been - autopsies conducted at
7 the Hospital on children who died elsewhere than
8 at the Hospital for Sick Children, I take it that
9 some of those deaths were attributable, at autopsy,
10 to missed-SIDS and not SIDS per se?

11 A. Yes.

12 Q. Do you know what the break-
13 down is amongst those, in those 397 cases, Doctor?

14 A. No, I do not.

15 Q. Have you made it a point of
16 interest in your continuing research to keep track
17 of the cases which at post mortem are determined to
18 be missed-SIDS, terminal diagnosis, as opposed to
19 SIDS, per se?

20 A. We have an approximate idea
21 but we do not know exactly, no.

22 Q. Can you help me as best you
23 can, if you have the figures available to you, in
24 approximate terms what you understand that breakdown
25 to be?

A. Many of those cases came or



1
2 were in the Hospital for Sick Children probably fall
3 into that category of missed-Sudden Infant Death
4 Syndrome.

5 Q. I am sorry, Doctor, I was
6 talking about the 397 cases in respect of which the
7 deaths had not occurred at the Hospital for Sick
8 Children?

9 A. I am sorry, no, I do not
10 know about that.

11 Q. You have told me that of the
12 24 cases where the 'children died at the Hospital for
13 Sick Children you think most of those would represent
14 terminal diagnosis of missed-SIDS as opposed to
15 SIDS per se?

16 A. Yes, a good portion.

17 Q. In respect again of the
18 24 cases, the Hospital for Sick Children cases, do
19 you recall Mr. Roland suggesting to you during his
20 examination that most of those 24 cases would probably
21 have come to the Hospital for Sick Children as a
22 result of an apneic episode. Do you recall that?

23 A. Yes.

24 Q. And you said, as I understood
25 your evidence, that you thought that was likely so.
You said, yes, unless they had been brought in for



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some other reason and it was discovered that they had had a spell of apnea, when they were in the Hospital?

A. Yes.

Q. Is it on that basis, Doctor, that you suggest to me that those 24 cases were likely all missed-SIDS cases as opposed to SIDS per se?

A. On that basis plus the morphological findings I would assume.

Q. You told me in chief, Doctor, as I recall it, that you were not aware how many of those 24 cases in fact represented children who had been admitted to or at least had died on the cardiology wards in the hospital. Do I have that correctly?

A. Yes.

Q. How many, if you are able to help me, Doctor, of those 24 were on both the cardiac and the apnea monitor at the time of death, or do you know?

A. I don't know.

Q. Do you know how many, sir, were neonates - under 30 days of age?

A. In the total group?



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Q. Of the 24.

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A. In the 24, no, I do not
know that.

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Q. Can you help me, of the
group of 24, how many children had normal birth
rates or do you have that kind of information avail-
able to you?

8

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A. No, we were not looking at
the epidemeological information.

10

11

Q. Do you know how many of
those 24 cases were referred to the coroner?

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A. No, I do not.

MR. SCOTT: Mr. Commissioner, I
am curious about what this has to do with and perhaps
I might be told at some stage. I do not want to
interrupt it, but I would like to know what I am
facing here.

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THE COMMISSIONER: I suppose it is
to improve our knowledge of SIDS, I suppose that is
what it is, if we are going to become experts on the
subject.

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21

MR. SCOTT: We are the experts on
seminars so we will run one on that if you would like.

22

MS. CRONK: May I have an invitation?

23

MR. SCOTT: I think that the evidence

24

25



1
2 was adduced initially in order to show this Doctor's
3 particular interest and expertise.

4 THE COMMISSIONER: Well, we do not
5 have - obviously you are not going to get any further
6 statistics, I do not think.

7 MS. CRONK: No, I was just interested
8 in whatever information the Doctor had maintained in
9 on-going research files with respect to these cases.
10 I thought that would be of help to this Commission
11 to know, in the experience of the Hospital for Sick
12 Children, how many of those children were in fact
13 neonates, as was Jordan Hines, and how many of those
14 in fact were reported to the coroner, because we know
15 that the Hines case was not.

16 It appears that the Doctor does not
17 have that information, and I intend to leave it there.

18 Q. Dr. Becker, do you recall
19 as well being asked by Mr. Roland whether SIDS is
20 now recognized as the number one cause of death for
21 children between the age of one week and one year?

22 A. I understand that is so, yes.

23 Q. I take it then you recall
24 the discussion; when he asked you that, you agreed
25 with that premise?

A. Yes.



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Q. Do you remember him suggesting as well that in the United States there were over 7000 crib deaths per year and you agreed with that, as I understood your evidence?

A. Yes.

Q. And finally he suggested to you that SIDS is the cause of death for one in every 500 babies born and as I understood your evidence you agreed with that?

A. I believe I did - actually - yes.

Q. Do you recall that exchange?

A. Yes.

Q. Do you have some hesitancy with that today?

A. The incidence is two per 1000 approximately.

Q. By my rather simple mathematics, maybe that works out to --

A. Yes.

Q. Thank you, Doctor. Maybe I'm missing some subtlety there.

Do you recall as well, Dr. Becker, referring Miss Symes during the course of her examination to an article by Dr. Naeye and indicating



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2 that he had looked at apnea children under the age
3 of one month and found that with a single
4 apnea spell the risk of death was approximately
5 5 per cent. Do you recall that?

6 A. Yes.

7 Q. And after that, if there
8 was more than one apnea spell, it was 44 per cent.
9 Do you recall that exchange?

10 A. Yes.

11 Q. Doctor, I am going to ask
12 you to look at Exhibit 163, Mr. Registrar, if you
13 could provide that to Dr. Becker if you would.
14 You will see that that is an article by Dr. Naeye
15 entitled "Sudden Infant Death". It was marked by
16 Mr. Scott as Exhibit 163 in these proceedings.

17 Is that the article which you had
18 in mind when you referred Miss Symes to an article
19 by Dr. Naeye?

20 A. No.

21 Q. Is there another one by
22 him that specifically deals with the question of risk
23 of death?

24 A. Yes, there is.

25 Q. Perhaps in due course if
you would be kind enough could you through your counsel



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provide us with a copy of that article?

A. Yes.

Q. With respect to the one before you specifically, I would refer you to the full first paragraph on page 1 in the left-hand column. Do you have that page 1, Doctor?

A. Yes.

Q. In the first paragraph it refers to the phenomena known by the initials SIDS and it goes on to say, at least the observation is made by the author that:

"It is often called crib death or cot death, since it usually happens while the baby is sleeping. In the U.S. it kills about 7000 infants per year, or about one out of every 500 babies born, ..."

Stopping there, this appears to be the article from which Mr. Roland was drawing his statistics which he put to you yesterday.

A. Yes.

Q. Do you agree that that is a fair conclusion?

A. Yes.

Q. And it continues:



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"...making it the most frequent cause of death between the ages of one month and one year."

A. Yes.

Q. I take it we can agree, Doctor - or would you tell me if you do agree then, that on the basis of Dr. Naeye's article the suggestion is not made that it is the most frequent cause of death for children between the ages of one week and one year, as was suggested to you?

A. In that particular article, although there are others that suggest otherwise.

Q. Perhaps we could continue then, Doctor. If you could turn to page 4 of this article, it is not numbered page 4, but it is the fourth page in in the copy that I have, we see two graphs or charts there. They both deal with age. Do you have that - the one on the top of the page?

A. Yes.

Q. Entitled "Age (months)"

A. Yes.

Q. And underneath it is a description of "Infant deaths in the United States..." Do you see that?

A. Yes.



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Q. And in the last sentence under
that chart it is indicated:

"The syndrome is the most frequent
cause of death between the ages of
one month and one year, and at one
age it exceeds all other causes."

A. Yes.

Q. Do you see that, Doctor?

A. Yes.

Q. I believe you told Mr. Tobias
during his examination, sir, that you were familiar
as well with Exhibit 180 which you may recall, to
help you, is an article that appeared in the British
Medical Journal earlier this year, in April, I
believe.

You may not need the article itself,
Doctor. You may recall it. It is the one that
appeared in the British Medical Journal to which Mr.
Tobias specifically referred you.

My question is simply this, based
on your familiarity with that article, were you aware
that of the 29 deaths studied by the authors of that
article and reported upon in that study, only two were
infants less than one month of age in respect of whom
SIDS was found to be the terminal diagnosis or, in



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Becker, re.dr.
(Cronk)

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respect of whose death SIDS was a contributing cause.
There were only two, and in each of those cases both
were marginally less than one month of age. Were you
aware of that, Doctor?

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A. Yes. We have our own statistics in that regard. We found there are 8 per cent under the age of one month in terms of the total number of SIDS; and in terms of the week 1 to week 4, 7 per cent. So 7 per cent is the figure that we have on the children that we have seen that have died of Sudden Infant Death Syndrome.

Q. That is very helpful, Doctor. Let us deal with it in two stages if we may. When you say based on your own statistics, are those statistics compiled at The Hospital for Sick Children?

A. They were a brief rundown of the cases of Sudden Infant Death Syndrome that we have had, yes.

Q. Are you referring to the total 421 autopsies?

A. Yes.

Q. Or are you referring simply to the deaths that occurred at The Hospital for Sick Children?

A. It is referring to the total number of autopsies.

Q. So of the 421, are you telling me then that 8 per cent of those cases involved infants under the age of one month?



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A. Yes.

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Q. And of those there were 7 per cent

4

between one week and the fourth week?

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A. Yes.

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Q. And that is over a 10-year period?

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A. Yes.

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Q. Doctor, the obvious point of the

reference ---

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THE COMMISSIONER: That is one week

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and four weeks, or one week and one month? I don't

11

know why I get so excited about that sort of thing,

12

it is three days, but it does seem odd that you would

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take it ---

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THE WITNESS: Four weeks or a month, yes.

15

THE COMMISSIONER: Which is it? I am

sorry I raised the question.

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MR. SCOTT: You have a great future as

17

a research scientist.

18

MS. CRONK: Q. The percentage in fact

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may not change. I take it, Doctor, that on the basis

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of the cases that have been dealt with in that 10-year

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period at The Hospital for Sick Children, despite the

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suggestions that we see in the literature, that it

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is unusual to find a death in a neonate child of one

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month being attributable to SIDS that has not

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statistically been the case with the cases you have reviewed at The Hospital for Sick Children, you have had as much as 8 per cent?

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A. That is correct.

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Q. I take it then, Doctor, you would disagree with the suggestion which we see in a number of the articles that have been filed before the Commission, that in fact with respect to SIDS it is most unusual for a child during the first month of life to have life claimed attributable to SIDS?

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A. I don't really agree with your word "unusual" at all.

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MR. SCOTT: What are the articles?

14

MS. CRONK: There are a number of articles, Mr. Scott, but I was trying to abbreviate it.

15

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MR. SCOTT: Could you give me the names for the record because I think there are not.

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MS. CRONK: Q. First, Dr. Becker, I referred you first to Dr. Naeye -- I am sorry, it is the word "unusual" that you are having difficulty with?

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MR. SCOTT: It is most unusual that I have reference to.

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MS. CRONK: Q. All right, let's deal with one specifically. Doctor, I provided a copy of this article to you previously in addition to the one



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that we already have marked before the Commission.

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THE COMMISSIONER: Is that 163?

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MS. CRONK: I referred first to Exhibit
163 and then to Exhibit 180.

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THE COMMISSIONER: This is something
new, is it?

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MS. CRONK: This is an article that I
provided some time ago to Dr. Becker.

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THE COMMISSIONER: Oh, but it hasn't yet
been provided here?

11

MS. CRONK: No, sir.

12

THE COMMISSIONER: All right.

13

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MS. CRONK: Q. This particular article,
Dr. Becker, is an article by Dr. Guntheroth entitled:
"Editorial: The QT Interval and Sudden Infant Death
Syndrome".

15

16

A. Yes.

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Q. Do you recall seeing this article
before?

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A. Yes.

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Q. And I am referring to the second
paragraph on the first page; I am sorry, the third
paragraph of the first page, and unfortunately the
copy is not terribly clear, in which the author
suggests:



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"A relatively rare characteristic of the epidemiology of SIDS is the sparing of the first month of life; SIDS occurs between one and six months of age."

I take it, Doctor, on the basis of what you have told us, that the experience at The Hospital for Sick Children in respect of the autopsies conducted on SIDS victims would lead you to disagree with that observation?

A. There are other people that have found similar things to what we found too, we are not the only ones that have been aware that Sudden Infant Death Syndrome occurs in the first month of life.

THE COMMISSIONER: All right, we will make the article Exhibit 200.

MS. CRONK: 200, sir?

THE COMMISSIONER: Yes.

MS. CRONK: Thank you.

--- EXHIBIT NO. 200: Excerpt from: "Editorial: The QT Interval and Sudden Infant Death Syndrome by Warren Guntheroth, M.D."

MS. CRONK: Q. And finally, as the matter has been given some issue by my friend Mr. Scott, if I could refer you to Exhibit 161, Mr. Registrar.

THE COMMISSIONER: 161, he has already got it, apparently.



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MS. CRONK: Q Do you have 161, Dr.
Becker?

A. Yes.

Q That as you recall is an article
by Dr. Shannon and Dr. Kelly entitled: "SIDS and near-
SIDS", and I simply suggest that reported in that
case is the same suggestion that we see in other
articles, and I refer you to page 962, at the bottom
of the column on the left-hand side of the page in
which the following appears:

"Most investigators have focussed on
events surrounding the time of death
and the preceding weeks. Infants tend
to die asleep, at night, in any
position, between the ages of one and
four months, and during winter months."

And I take it no further than this,
Doctor, that it would appear on the basis of some
of the literature to which you have referred, and which
has been marked as exhibits before this Commission,
that there is some suggestion that it is at least
infrequent for neonates to have their lives claimed
by SIDS during the first month of life? Can we agree
to that?

A. Our experience is that it is about
8 per cent.



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Q Well, you have told me that,
Doctor, and I don't think I can take it any further.
Thank you.

Doctor, as well you may recall being
questioned by Mr. Ortved as to the sequence of events,
or the chronology as he described it, that applied
on March 25th, 1981, with the completion of the
autopsy reports.

MS. CRONK: I am sorry, Mr. Commissioner,
I have lost track of the time.

THE COMMISSIONER: No, I think it
would be a good idea, are you close to finishing?

MS. CRONK: Yes, I am, sir.

THE COMMISSIONER: Yes, I think it
would be a good idea to finish.

MS. CRONK: Q You remember telling
Mr. Ortved, Dr. Becker, that as of March 25th, 1981,
all of the autopsies that had been done in the last
week, or several weeks at the Hospital, were requested
to be completed as quickly as possible?

A That was my understanding at that
time, yes.

Q Can you help me as to why that
was the case, what was your impression as to why that
request was made?



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A. My understanding was that there was an ongoing investigation by the Toronto Metropolitan Police at that time, whether it was an investigation, I wasn't sure exactly who was involved.

Q. So I take it then, Doctor, that as at the 25th of March you were aware that the Metropolitan Toronto Police were involved in investigating a number of infant deaths at the Hospital?

A. I was aware they were involved in an investigation, yes.

Q. And you have told my friend Mr. Tobias during cross-examination as well, that as best you can pinpoint it the preliminary autopsy report for Jordan Hines would have been prepared either on March 23rd, or on March the 24th, but you thought it likely it was the 23rd; do I have that correct?

A. Yes, it is difficult for me to say which, as I mentioned before, but probably one of those two days, yes.

Q. Doctor, can you help me with this, by the time of preparing the preliminary and final autopsy reports on Jordan Hines on the 23rd and through to the 25th, were you aware of the high postmortem digoxin levels which had been reported in respect of Kevin Pacsai?



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A. Not as far as I know.

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Q. Similarly at the same time frame, as at March 23, March 24, March 25 when you were preparing these autopsy reports, were you aware of the high postmortem digoxin levels that had been reported in respect of Janice Estrella?

A. I don't recall whether I was aware that there were elevated levels, or whether there was a problem with digoxin. It seems likely I may have been aware of it but I don't recall being aware of it.

Q. Did you know at that stage, that the death of that child had been reported to the coroner by your colleague, Dr. Mancer?

A. I don't believe I knew that, no.

Q. Were you aware at that time, in the same time frame, Doctor, of the high postmortem digoxin levels that had been reported on Allana Miller over the course of the weekend?

A. No.

Q. Were you aware, Doctor, that on the Sunday, on the 22nd of March, before you would have completed the preliminary autopsy report on Jordan Hines, that high antemortem and high postmortem digoxin levels had been recorded on Justin Cook?



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A. I was aware that there was digoxin, there was probably digoxin in those children, but I wasn't aware of where the digoxin was from, or the levels, to the best of my knowledge.

Q. But I take it by the time, the conclusion of that weekend, when you were at work on the 23rd of March, you were aware that there was a difficulty in that regard?

A. Yes, I probably was aware of that.

Q. And at that stage, having regard to the events of that weekend; let me ask you one other question and perhaps you can shed some light on this for us. Dr. Ellis' digoxin books have been filed as exhibits before this Commission, and Dr. Ellis is being called back in the future to give further evidence in respect to the contents of them.

There is the suggestion made in an entry for March the 20th, 1981, that assays for digoxin were run post mortem on tissue samples from the body of Jordan Hines on the 20th of March, 1981. Were you aware, Doctor, of any digoxin assays being run at The Hospital for Sick Children on this child in March?

A. No.

Q. You don't have any knowledge with



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respect to any postmortem tissue testing, or post-mortem blood testing, whatever it might be, in respect of that child?

A. No.

Q. Doctor, given the events of the weekend of March 21st through March 22nd; and given your state of knowledge of those events as you have described it when you came into the Hospital on Monday, March the 23rd, did it occur to you at that stage that there might be some contributing factor played in the death of Jordan Hines by virtue of digoxin?

A. No. I thought the diagnosis was Sudden Infant Death Syndrome after we had looked at the slides.

Q. I take it then that when you completed the preliminary autopsy report on the 23rd and 24th, as you have told us, and completed the final autopsy report on the 25th, that was not a matter that occurred to you at that time?

A. No.

Q. Finally, in respect of one other area; you will recall that you told Mr. Roland when you prepared the autopsy report on Jordan Hines, that the doubt that you were expressing in that report



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concerning the arrhythmias which had been experienced by the child and noted clinically, had to do with the mechanism of his death. You indicated that you were not doubting your diagnosis at that time, but rather the mechanism or the method by which the child had died. Do I have that correctly?

A. Yes.

Q. And do you recall as well when Mr. Roland asked you why in light of that you had expressed that doubt in the autopsy report, and you answered as follows. To be fair, Doctor, perhaps I can just simply read it to you?

MR. SCOTT: The volume and page, please?

MS. CRONK: Volume 39, page 7728, and the question was:

"Can you tell us, in reflection, having reviewed that report, why you think you put that doubt on the autopsy report in the form of a question mark and so on? What was the reason for doing that in this particular case?

"A. I certainly wanted to convince Dr. Wilson that it would be worthwhile to do the conduction system of the



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And if we turn to the next page:

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"heart, to show that it was important in this instance, that it should be done, and suggest to him that there was a possibility that there could be an abnormality in the conduction system.

"Q. You have told us that you did not really think there was an abnormality; you thought it was a normal heart?

"A. Yes.

"Q. And you really wanted a conduction study in order to exclude the possibility of an abnormality in the conduction system of the heart; is that correct?

"A. Yes."

"Q. If you had not been interested in doing research in SIDS, would you have raised that possibility at all in your autopsy report, do you think?

"A. No.

"Q. So, it was really as a researcher that you raised that possibility?

"A. Yes, it is.

"Q. That, I gather, was, as you have



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"said, put in the autopsy report to really bolster your case with Dr. Wilson, was it not; to convince him that he should do a conduction study of the heart?

"A. I think it probably was.

"Q. And if Dr. Wilson thought that it was simply an ordinary heart, a heart that was not abnormal, he, I gather, would not be particularly interested in doing a conduction study?

"A. I do not think so."

Q. Doctor, at the time of preparing the autopsy reports, as I understand it Dr. Wilson was not scheduled to start at The Hospital for Sick Children until the beginning of July?

A. Yes.

Q. That summer, is that correct?

A. That is my understanding.

Q. Did you know at that time that his appointment was not going to be effective until the 1st of July?

A. Yes.

Q. Were you aware at the time of preparing those reports as well that Drs. Fowler and



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Rose would be interested in the post mortem results
on this child?

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A. No, I was not particularly aware
of that.

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Q. Were you aware that Dr. Rose had
attempted to obtain details as to the post mortem
results from someone in the Pathology Department?

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A. No, I wasn't.

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Q. You told me earlier that except
for the one conversation that you described to
Mr. Ortved, that you don't recall having had any
discussions with Dr. Rose concerning the post mortem
results of this child. Do I have that correctly?

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A. Yes.

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Q. I take it we can agree, Doctor,
however, in light of your previous evidence, that you
were aware that her clinical diagnosis had been viral
myocarditis?

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A. Yes.

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Q. Can we agree as well that it would
be likely in that situation that she would be
interested to know whether or not that clinical
diagnosis had been borne out, or whether it had been
ruled out?

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A. Yes.

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Q. And you knew at that stage as well, you have told us, Doctor, that the Metropolitan Toronto Police were in the Hospital?

A. Yes.

Q. And were carrying out an investigation?

A. Yes, I assumed so.

Q. And I believe you also said in evidence that you knew at that stage, you assumed that the coroner would be provided with a copy of the autopsy report in due course, having regard to the fact that the police were involved?

A. I wasn't sure exactly how the coroner was involved. I knew there was a police investigation but I made the assumption that there was probably some interrelationship between the two.

Q. Was it your expectation at that time that the autopsy report would go to the police?

A. At the time the report was completed?

Q. Yes.

A. I had assumed there would have been - that would have been taken, yes.

Q. Yet at the time, based on those events, at the time you expressed a doubt in the



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report, which as I understood your responses to Mr. Roland, you yourself didn't entertain as being likely, that is, that you suspected ---

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MR. SCOTT: I am sorry, go ahead with the question.

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MS. CRONK: Q. As I understood your responses to Mr. Roland, you yourself thought there was no abnormality in the conduction system, and you anticipated that the study would in fact prove you out in that regard?

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MR. SCOTT: Mr. Commissioner, this examination is becoming a little hyper-aggressive. The questioner fails to understand that an autopsy report in a hospital, even on March 20th, is a research instrument, it is not a forensic instrument. It seems to me it is entirely unfair ---

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MR. TOBIAS: Excuse me, what is the reference in the evidence to that statement, Mr. Scott, can you point it out to me in the transcript where that evidence is?

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MR. SCOTT: Well, I can't get it for you just now.

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MR. TOBIAS: Perhaps you can find it at the break?

MR. SCOTT: Maybe Dr. Mancer will tell you.



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THE COMMISSIONER: I don't care what happens, Dr. Becker is leaving these premises before any of us are allowed a cup of coffee, there is nothing provided after the break.

MR. SCOTT: That is fine. I want to emphasize my objection of what I think is an unfair suggestion. What the witness is being - what the question suggests is that because Dr. Becker viewed the autopsy report as a research instrument, that in some fashion he misled somebody and that is not fair at all.

Now, if Miss Cronk suggests that, let's have it out because I want to know what her position is? Perhaps she can tell me.

MS. CRONK: I thought I had. The question can very simply be resolved at this stage perhaps. Dr. Becker, I ---

MR. SCOTT: Perhaps you can tell me before we have the question ruled on?

THE COMMISSIONER: Well, I am sorry, I am not exactly too sure what your objection is. If the objection is that she is being a little too aggressive ---

MR. SCOTT: Well, that I just have to live with I suppose.



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THE COMMISSIONER: You can't do anything about that.

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MR. SCOTT: That I will have to learn to live with and I will try. The question is put with this foundation. You have told us, Dr. Becker, that in your autopsy report you made a suggestion by virtue of a query in order to encourage Dr. Wilson to permit ---

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THE COMMISSIONER: Yes.

MR. SCOTT: --- permit a conduction examination. Now, what is being suggested is that - and you knew that that was going to the police?

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THE COMMISSIONER: Yes.

MR. SCOTT: That raises an unfair inference and I object to it.

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MR. SCOTT: Is my friend ---

THE COMMISSIONER: It may not be effective, but that is what it relates to.

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MR. SCOTT: Let's have that out, is my friend attacking the credibility of this witness?

THE COMMISSIONER: I don't know, I don't think Miss Cronk has to answer that at all. She as



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Commission counsel surely has to prove the validity
of every statement made by every witness.

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MR. SCOTT: Yes.

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THE COMMISSIONER: She doesn't have to
take it to heart, mind you, if he says it was raining
that day, she doesn't have to go into that, but she
certainly is entitled to probe that; and on the face
of it there is something needing explanation, there
always was. We have had at least 28 explanations of
those last four lines.

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MR. SCOTT: At the risk of prolonging
the coffee break indefinitely, I am going to ask, if
this line of questioning is permitted, to ask some
subsequent questions.

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THE COMMISSIONER: Well, he is going
to ask and I haven't said he could yet. You carry on
now, please.

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MS. CRONK: Q. The point perhaps is
simply this. Dr. Becker, I have heard your evidence
with respect to why a doubt was contained, or expressed
in the final autopsy report. You have told us that
you hoped in due course when Dr. Wilson arrived some
three months later, to persuade him that it would be
a valuable exercise to embark on a study of the
conduction system of this child.



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I also understood you to say, however, in evidence, in your responses to Mr. Tobias this morning, that you felt the inclusion of the reference to carrying out a conduction study, was relevant as well to the cause of death of this child and was not purely an academic exercise.

I merely suggest this to you, Doctor, and I ask you to tell me whether you agree or disagree? Having regard to what the events were, or the facts were in the Hospital on the 25th of March when that report was signed, is it not possible that including language of that kind, given a complete understanding of what you hoped to do with it later on with Dr. Wilson, might have had the result of misleading others as to what your true opinion was as to the cause of death of this child?

A. No, I thought I was actually helping in terms of explaining how the child died and trying to give an explanation in terms of the apnea hypothesis and suggesting this is how you could put together the mechanism of death in a child that dies of Sudden Infant Death Syndrome. And by putting together a mechanism for death in Sudden Infant Death Syndrome I had to agree that by doing that that is still a hypothesis. I can't be absolutely certain



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of that. I think I have mentioned that several

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times. So the query is partly academic, and it is

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also partly an attempt to help in terms of under-

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standing the mechanism of death.

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Many people avoid talking about mechanism of death in Sudden Infant Death Syndrome and I instead answered that problem I thought directly.

Q. All right, I think I understand your evidence better now, Doctor. I take it then that the inclusion of that suggestion and the expression of that doubt was not in your mind purely addressing an academic issue, it was in fact serving a dual purpose as you then saw it?

A. Yes.

MS. CRONK: Thank you, Doctor. Thank you for your patience. I have no further questions, sir.

MR. SCOTT: I have two questions.

THE COMMISSIONER: Well, can you just tell me what they are first.

MR. SCOTT: All right. The first deals with the first point Miss Cronk made when she asked the Doctor to concede that Dr. Wilson was not going to begin until July, assuming that question is based, is an attack on his credibility, that is, he made ---

MS. CRONK: It is not at all, it is a confirmation of what he ---



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THE COMMISSIONER: All right.

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MR. SCOTT: Well, I've just got to
deal with one of you at a time, please.

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THE COMMISSIONER: Please, all right.
Ask that question.

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MR. SCOTT: That's the first
question.

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THE COMMISSIONER: Ask that question.

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MR. SCOTT: All right.

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THE COMMISSIONER: Let's get that
one out of the way.

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FURTHER RE-EXAMINATION BY MR. SCOTT:

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Q. Now, Dr. Becker, you were
asked by Ms. Cronk whether you made this report
knowing that Dr. Becker would not come on staff at
the Hospital until July.

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A. Dr. Wilson, yes.

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Q. I'm sorry, Dr. Wilson.

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A. Yes.

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Q. Did you know he was coming
on staff?

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A. Yes. Dr. Wilson was a
resident at the Hospital for Sick Children the year
before and he was completing his residency at the,
I believe at that time he was at the Toronto General

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2 Hospital. So, I knew him well and I knew that he
3 was coming back to the Hospital for Sick Children.

4 Q. Yes. And notwithstanding
5 your questioning by Miss Cronk now, at Volume 38,
6 page 7705 I want to read you a question of the
7 Commissioner.

8 THE COMMISSIONER: Oh, all right.
9 I wish you wouldn't hold those facts against me.
10 What is the purpose of that one now, please.

11 MR. SCOTT: To show that he gave
12 to the Commission at an early stage, during the
13 early examination by Miss Cronk, this very explanation
14 and to come back on it is not re-examination.

15 THE COMMISSIONER: All right.

16 MR. SCOTT: The Commissioner said,
17 at line 10, speaking of the conduction studies:

18 "THE COMMISSIONER: Could you have
19 done that yourself?

20 THE WITNESS: No, I could not have
21 done the conducting system. What I
22 had planned on doing was having Dr.
23 Wilson, who is a cardiopathologist
24 and whom I knew was coming on staff
25 in July of 1982 and my intention was
to convince him to do conduction



Becker, re.ex.
(Scott)

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"systems of the heart. He had done
it before. But it is not a pro-
cedure that any pathologist can do."

Now, did you give that answer and
does that remain your evidence?

A. I think it was 1981, was
it not?

Q. Well, it says 1982. Should
it have been 1981?

A. It should have been.

Q. All right. Apart from that.

A. Yes.

Q. Apart from that is that your
answer?

A. Yes.

Q. Yes.

THE COMMISSIONER: Yes, all right.
Now, the next question, please.

MR. SCOTT: The next question is,
was there anything that led Dr. Becker to believe
that his final autopsy report would be read by Ms.
Cronk or anybody else as a forensic report?

THE COMMISSIONER: Can I answer that?

MR. SCOTT: Yes.

THE COMMISSIONER: No. All right?



Becker, re.ex.
(Scott)

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2 MR. SCOTT: Well, if the answer
3 on the record is no.

4 THE COMMISSIONER: No, no, that is
5 my answer, it is my answer. How could he possibly -
6 he is a pathologist, he is not concerned surely as
7 to whether it is to be a forensic report at some time.

8 MR. SCOTT: Precisely. But Miss
9 Cronk's ---

10 THE COMMISSIONER: But, all right,
11 this is argument.

12 MR. SCOTT: But Miss Cronk's question
13 is, and I think she used the word "mislead".

14 THE COMMISSIONER: Now, the question
15 that Miss Cronk - if I can do this. I would like to
16 save this for argument but the question is that it
17 was worded in such a way that some people, including
18 a great many counsel around here, have read it that
19 the arrhythmia took away from SIDS?

20 MR. SCOTT: Yes, yes.

21 THE COMMISSIONER: That's all,
22 that's all she's trying to say. Would it not have
23 been better, if he had his life to live over again,
24 he might write it differently?

25 MR. SCOTT: No, but Dr. Rowe



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explained that early in his evidence.

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THE COMMISSIONER: Yes, yes, all right.

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MR. SCOTT: But leaving that aside---

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MR. TOBIAS: Where was that, Mr. Scott?

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MR. SCOTT: It was in my cross-examination and I will have to find Mr. Tobias the volume and page in due course if he will approach me privately.

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THE COMMISSIONER: All right.

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MR. SCOTT: The reason I ask the question now is because Miss Cronk used the word "mislead" and I think that is unfair.

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THE COMMISSIONER: Yes, all right, I have your submission. I certainly will take it into consideration. There is no need to ask another question with respect to it.

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Miss Cronk, now, I have to in fairness come back to you. Have you any more questions, I hope not?

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MS. CRONK: My only remaining question, sir, is may we all have a coffee?

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THE COMMISSIONER: Yes.

MR. SCOTT: Well, Mr. Commissioner,



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I am troubled about this.

THE COMMISSIONER: I know you are.

MR. SCOTT: Because a number of witnesses have given evidence at this inquiry and they have done so in a detailed and full fashion. It has never been suggested by Commission Counsel that any of them have sought to mislead anybody.

THE COMMISSIONER: No, I would like to speak for Miss Cronk here just in case she is going to say something different. It is not an attempt to say that he was trying to mislead anyone, that's not it. It is the fact that having put it in that particular way might have resulted in people misunderstanding, not that there is anything deliberate, not that there is anything sinister about the whole thing at all, it is worded that way and the proof of the fact is that we have been arguing about what those last four lines mean.

MR. SCOTT: I would be so happy if Miss Cronk would acknowledge that.

MS. CRONK: Well, Mr. Scott, there is no difficulty. I would like Dr. Becker to be very clear about it too as he is about to leave the witness box. It was not my intention nor my language to suggest that he had misled.



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THE COMMISSIONER: No.

MS. CRONK: But rather that the language of the report may have had the effect of misleading not only a number of the lawyers in the room but the four cardiologists, Dr. Rowe, Dr. Fowler and Dr. Rose.

THE COMMISSIONER: All right.

MS. CRONK: No more than that. And Dr. Mancer.

THE COMMISSIONER: Thank you Doctor. Would you promise me faithfully that when we come back here in 20 minutes you will not be around.

THE WITNESS: Certainly will not be.

THE COMMISSIONER: Yes, all right.

--- Witness Withdraws.

--- Short Recess.

--- Upon Resuming.

THE COMMISSIONER: Yes, Mr. Lamek.

MR. LAMEK: Mr. Commissioner, I would call Dr. Kent Mancer.

JAMES FREDERICK KENT MANCER, Sworn

DIRECT-EXAMINATION BY MR. LAMEK:

Q. Make yourself reasonably comfortable in that small space, can you not.



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Dr. Mancer, I understand that you graduated from the University of Manitoba in 1965 with a degree of Doctor of Medicine?

A. Yes, I did.

Q. And subsequently did an internship in Winnipeg and then a residency in pathology at the University of Washington Hospital in Seattle?

A. That's correct.

Q. You hold certificates in pathology from the American Board of Pathology and from the Royal College of Physicians and Surgeons of Canada?

A. Yes, I do.

Q. And are a Fellow of the Royal College in Pathology?

A. Yes.

Q. Canadian College that is?

A. Yes.

Q. You have been at the Hospital for Sick Children in Toronto as a pathologist since 1971 I understand?

A. That's correct.

Q. From 1973 you were senior staff pathologist?



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A. Yes.

Q. And in 1983, this year,
became Deputy Chief of the Department of Pathology?

A. Yes.

Q. And you hold also an
Associate Professorship in Pathology in the Faculty
of Medicine at the University of Toronto?

A. That's correct.

Q. Doctor, you are a member of
a number of professional societies, published a
large number of papers and presented papers at
meetings of professional and other learned societies?

A. Yes.

Q. And I won't embarrass you by
a recital of them. There are two however which I
would like a little more information if I may.

In October of 1979 you made a
presentation as I understand it to the Pediatric
Pathology Club in Providence, Rhode Island?

A. Yes.

Q. On the subject of pediatric
homicide, a session on Pediatric Forensic Pathology?

A. Yes.

Q. Can you just tell me what that
is, it obviously peaks my interest at this stage.



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A. Well, the Pediatric Pathology Club is a North American organization of pediatric pathologists. In that particular year they wanted to make forensic pathology one of their subjects of discussion.

Q. Yes.

A. A theme.

Q. And in particular what did you address them about?

A. I gave them a talk on our experience with homicide over the period that I have been at the Hospital for Sick Children. We have been doing the forensic autopsies for children for Metro Toronto during that time, all the time I've been here.

Q. And in 1981, in August of 1981 you made a presentation to the Canadian Society of Forensic Sciences at its meeting in Hamilton, Ontario on the subject matter of homicide in children?

A. Yes, that's correct.

Q. And what was the thrust of that discussion, please?

A. Well, it was essentially the same talk.

Q. Okay. Do I take it neither of



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those were addressed to the question of homicide or possibility of homicide within a hospital?

A. That's correct.

Q. All right. Although you have as I understand it been present at sessions when that subject matter was discussed.

A. Yes. Since the events of 1980/81.

Q. Yes. Mr. Commissioner, I wonder if we might file Dr. Mancer's curriculum vitae as Exhibit 201.

THE COMMISSIONER: Yes, 201, please.

--- EXHIBIT NO. 201: Curriculum Vitae of
Dr. James Frederick Kent
Mancer.

MR. LAMEK: Q. Dr. Mancer, there are three particular matters that I want to ask you about. First, you were the pathologist in charge of the autopsy of Janice Estrella, were you not?

A. That's correct.

Q. The autopsy was performed as I understand it by Dr. Glen Taylor?

A. That's correct.

Q. Who was then a resident?

A. Yes.



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Q. But he was working in that regard, as no doubt others, under your supervision?

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A. That's correct.

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Q. Okay. Now, we have heard already from Dr. Becker about the pattern of procedure when an autopsy takes place in your hospital, about the resident's review of the chart prior to performing the autopsy and then his conducting of the autopsy subject to consultation, discussion with the staff pathologist and so on?

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A. Yes.

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Q. Do you recall whether prior to conducting the autopsy on Janice Estrella Dr. Taylor discussed the case with you at all?

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A. Yes, it is my recollection that he did.

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Q. Can you give us your best recollection of what was said between you prior to the autopsy?

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A. Well, this is very hard to reconstruct after so long.

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Q. I understand.

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A. It was even hard after three months.

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Q. Yes.



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A. When this became of

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importance.

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Q. I'm sure.

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A. But ordinarily my pattern is

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to call in myself to the Medical Records Department

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of the Hospital and find out what cases are going to

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be done on the weekend day. Like, I would call in

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at about eight o'clock or 8:30 in the morning and

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find out what is pending and after that, if there is

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something that is going to be taking place, then I

would have a conversation with the resident.

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Q. Yes.

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A. I have ordinarily got their

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telephone number and they have mine. So, we get in

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contact. I'm not sure who phoned who.

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Q. Yes.

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A. But we would have discussed

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it at that time and I believe I discussed with Dr.

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Taylor whether he thought he was capable of doing it

himself without my direct supervision and I

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believe that that was affirmed.

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Q. For how long had Dr. Taylor

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been a resident in pathology at the time of the

Estrella death in January of 1981?

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A. Well, he was in his last six

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months of training, so, he would have had three and a half years.

Q. Was there something about the Estrella case or the chart that made you suspect that perhaps he might feel less than confident in his ability to perform that autopsy?

A. No, only in that it might have been his first autopsy of his rotation at Sick Children's but he had had some pediatric pathology experience at the Vancouver General Hospital. So, he did feel confident I believe in going ahead.

Q. All right. And you I take it had no qualms about letting him go ahead?

A. That's right.

Q. Do you recall whether in the conversation which occurred between you and Dr. Taylor prior to the conduct of the autopsy, do you recall whether he mentioned that he had been asked to send a post mortem serum sample from the child for digoxin assay?

A. No, I don't recall anything like that, I'm sorry.

Q. Now, as at January of 1981 had there ever been to your knowledge any case at the Hospital for Sick Children where post mortem serum



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samples had been drawn for digoxin assay?

A. Not to my knowledge.

Q. And it is likely therefore I suggest that had he mentioned that at the time it is the kind of thing that would have stuck in your memory I would think?

A. Yes.

Q. Now, we have heard from Dr. Becker that occasionally in Coroners' cases, particularly post mortem blood samples may be taken at autopsy for drug screens, is that your experience too?

A. Yes.

Q. And have you ever been involved in such a case where blood has been drawn at autopsy for drug screens?

A. Yes.

Q. Could you tell us please what is the manner of drawing blood, the site from which it is drawn for those purposes?

A. Well, it's drawn from any blood vessel. In small babies we tend to use the sagittal sinus, that is, the large blood vessel in the top of the head where the soft spot in the baby head is and it is very easy to get a large blood



G-17

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sample from that site. It is easy to get a sample that is bacteriologically significant; that is, it is easy to get an uncontaminated bacteria sample; it is not easy in other sites.

Q. Is it not. Well, is that the nature of the tissue to which you have to penetrate to get to the vessel?

A. Yes. It is easy to sterilize the area and it is not a moist area after the scalp has been reflected and we can sterilize it quite easily by a hot device and then just put a needle into the vessel.

Q. Dr. Mancer, did you subsequently learn that Dr. Taylor had been asked to obtain blood samples at autopsy from Estrella for digoxin assay?

A. Yes.

Q. When did you learn that?

A. Well, as best we could reconstruct it would be at the time - well, it was at the sign-out of the autopsy but as best as we could reconstruct the time of the sign-out would have been March 3rd to 6th.

Q. When you refer to the sign-out of the autopsy you are referring to the signing of the



G-18

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final autopsy report?

A. Well, the preparation of the report that would later be signed after typing.

Q. And that is, as you recall, it was somewhere between March 3, March 6th?

A. As best as we could reconstruct after March the 20th - well, the week following the 20th.

Q. And did Dr. Taylor tell you at that time that he had received instructions to draw blood samples at autopsy for digoxin assay?

A. Yes.

Q. And at no time prior to that had you had any information that those orders had been given ?

A. That's correct.

Q. All right. Or that the samples had in fact been drawn and sent for assay?

A. No, I didn't know about that either.

Q. Or obviously therefore the results of the assay, you did not know until that time?

A. That's correct.

Q. All right. I wonder, Mr. Commissioner, if the Registrar would put in front of



1
2 the witness the Estrella chart. It is Exhibit 91,
3 sir.

4 Now, Dr. Mancer, the final autopsy
5 report begins at page 9 of that record. In fact,
6 there are two numbers on that page, a nine and a four.
7 If you look at the upper right-hand corner number it
8 is a nine.

9 A. Yes.

10 Q. And goes on - the textural
11 part of it goes to page 12 and there is then a
12 photograph and the detailed autopsy report that
13 follows.

14 I am interested particularly in
15 pages 9 to 12. Do you recall now, or what is your
16 best recollection of what Dr. Taylor did tell you
17 in the latter half of the first week in March, March 3
18 to 6 about the orders that had been given for the
19 drawing of the sample for digoxin assay?

20 A. Well, he told me that he had
21 been asked to take the sample by Dr. Freedom and that
22 he had done so. I believe he told me also that he had
23 not done so until the end, after the autopsy was
24 finished and he remembered that he should have done
25 so.

Q. Yes.



G-20

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2 A. And then he returned to the
3 Hospital morgue. This was actually after checking
4 with our Chief Resident who happened to be there at
5 the time whether he should take the sample at all.
6 The Chief Resident said yes, if you are asked to, take
7 it.

8 Q. Is that Dr. Gillan?

9 A. Dr. Gillan.

10 Q. Yes.

11 A. Right. So, the two of them
12 went down to the Hospital morgue and opened the body
13 again and were able to - like, blood samples should
14 come from within a blood vessel and they tried to get
15 some blood out of the leg veins by squeezing the
16 legs, elevating the legs and then squeezing from the
17 ankle up to the thigh, which has been referred to as
18 milking blood out of the vein. They could only get
19 a small amount.

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So Drs. Taylor and Gillan, recognizing that the small amount might not be enough, then took a quantity from the abdominal cavity and this was of course only partially blood. It would include a lot of other material.

Q. Dr. Mancer, Dr. Taylor will be here next week when he will tell us precisely what he said. I ask you, not for the sake of the accuracy and detail of what he did, but what your understanding was at the time of sign-out of this autopsy.

Dr. Taylor told you, as you have just now recounted to us, what he did and essentially how he did it.

A. Yes. I am not really certain whether that took place - whether I knew all of these details in the week of March 3rd or whether some of this comes from after we tried to reconstruct the case later, after it became of importance.

Q. As best you can, and I recognise the difficulty of trying to isolate what you knew at a particular time, but as best you can, can you tell me what you understood at the time of the sign-out of the report had happened with respect to the samples that Taylor said Freedom had told him to take?

A. I understand that they were taken -



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I understood that they had been taken in the way indicated.

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Q. Right.

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A. And then sent to the Biochemistry lab and then later on he received reports that he had tried to contact Dr. Freedom regarding the reports and he finally made contact with him. I am not sure, at the time that I discussed it with him, whether I knew that they had considered them to be so out of line that they were unacceptable or whether I only knew that much later, but I independently thought the same thing.

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Q. He reported the results to you at the end of the first week in March, then?

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A. Yes.

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Q. And which levels did he tell you about at that point?

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A. I knew about the level as being 72 nanograms per millilitre.

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Q. And your response to that information, I think you said, was that you regarded that as very much an out-of-line result?

A. That is right.

Q. Did its being out of line suggest to you that it was an unreliable or perhaps an invalid result?



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A. Yes, it did.

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Q. I want to come to that in a little

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more detail in a moment. Could we look at the final

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autopsy report, and it is signed by both you and

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Dr. Taylor, and that I take it is the standard

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procedure in the Hospital?

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A. That is correct.

9

Q. For the staff man to sign it, and

the resident who actually performed the autopsy?

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A. That is correct.

11

Q. I tell you, Dr. Mancer, that I

12

have not been able to find in this Hospital chart, a

13

preliminary autopsy report on Janice Estrella. Do

you know whether one was prepared?

14

A. I do not believe one was, or it

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would be in the chart.

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Q. Do you know why it was not?

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A. It was overlooked.

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Q. It is standard procedure, is it

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not, to prepare, in the normal course, a preliminary

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report shortly after the carrying out of the autopsy?

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A. That is right. It would ordinarily

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be done within a few days of the autopsy - supposed

to be done within about 24 hours.

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Q. Did you ask Dr. Taylor why no

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H.4

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preliminary report had been prepared in the Estrella case?

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A. No, I did not even know that until recently - I mean recently, about two weeks ago.

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Q. You were not conscious of not having seen a preliminary autopsy report on Estrella?

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A. That is correct.

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Q. Was it Dr. Taylor who prepared the draft of the final autopsy report for discussion with you and approval by you?

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A. Yes.

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Q. We are interested particularly, obviously, Doctor, in the final paragraph of the textural material, the pathological discussion on page 12 of this chart.

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Q. When Dr. Taylor came to you to have this autopsy signed off, was the pathological discussion portion prepared by him in draft?

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A. Yes.

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Q. Was the final paragraph beginning "Samples of postmortem blood were obtained ... " also prepared by Dr. Taylor in draft?

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A. I contributed to that paragraph. I believe I wrote only the last sentence but I may



H.5

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have written the entire paragraph.

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Q. I understand then that Dr. Taylor had included in his draft a reference to the postmortem samples and the results?

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A. Yes.

THE COMMISSIONER: I thought that was not quite what you said. I thought you said that you were not sure whether you wrote the whole paragraph?

THE WITNESS: No, I think - I know I contributed to it and I know I wrote the last sentence but whether I wrote the whole last paragraph is uncertain.

THE COMMISSIONER: The only point I am making, Mr. Lamek, is if he wrote the whole of the last paragraph then there would not have been anything in the draft of Dr. Taylor about the --

MR. LAMEK: Perhaps it was written in a different form and re-drafted.

THE COMMISSIONER: That is possible, too.

MR. LAMEK: That was really my question.

Q. Was there anything in Taylor's draft that reflected, whether in this final form or not, the taking of the samples, the measurements of digoxin recorded in those samples?



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A. At the time we signed the case out, that is the 3rd to the 6th range of March, I am not sure whether it was actually in the draft or not or whether we wrote it as a result of our discussion, but I became aware of it at that time and we discussed it. Whether he had it in the draft before he showed the draft to me, I do not know.

Q. It was in that context that he told you about the manner of obtaining the samples and so on. Did he tell you when he had received the results from the Biochemistry Department?

A. I don't think that came into our discussion, but it might have.

Q. You have told me you regarded the level that he told you about, of 72 nanograms, as very much out of line.

A. That is correct.

Q. I take it you regarded that as a rather startling digoxin level to be recorded?

A. Yes, an unbelievably high level.

Q. I understand that there had not been postmortem digoxin assays conducted in the Hospital prior to this case?

A. That is right.

Q. I take it you had some familiarity



H.7

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with antemortem levels and the general range of
therapeutic levels that might be experienced?

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A. I had to look that up. I am
not involved in digoxin therapy and when I was given
this level I had to look it up on tables and, actually,
the tables that I had were in different units and I
had to do calculations in order to arrive at what
were normal.

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Q. Having arrived at what was normal,
it was obviously clear to you that the number reported
to Dr. Taylor by Biochemistry, and to you by him, was
astronomically high, in relation to normal?

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A. Yes, that is correct.

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Q. Were you distressed or disturbed
by that level?

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A. Not really. It is so much above
what would be expected for a patient to survive with
that I could not see how, in the therapeutic situation,
such levels could be reached, so I therefore rejected
it as being valid.

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Q. Unless, as perhaps you suggested
in the final sentence of the pathological discussion,
the reason that the child did not survive was indeed
the very high level. That must have occurred to you
as a possibility?



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A. Yes. My statement is "if accurate", but I had my very strong doubts that this was a real reflection of the patient's measurement.

Q. Did you ask Dr. Taylor why he had not told you of this result in the orders that he received weeks earlier?

A. I don't know if I asked him that or not. Really, I did not - I doubt if I did because as I have said before I rejected this as being important at the time.

Q. Did you ask Dr. Taylor if he had made any inquiries of the Biochemistry Department as to the possibility of error in conducting the assay or as to error in recording the result?

A. I do not think I did.

Q. Did you, either then or at any other time, make such inquiries of the Biochemistry Department?

A. I did on March 20.

Q. But not until then?

A. But not before.

Q. Doctor, I do not intend to frame this in any pejorative way, but I do have it correctly that the number that was reported to you, March 3, 4, 5, 6, somewhere in there, was a number of so



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inordinately high an order that you rejected it without inquiry. Is that fair?

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A. Yes, it just did not seem logical.

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Q. Now, you have told us that the number that was reported to you was 72 nanogram level but you have also told us that you are aware that samples had been drawn, following the autopsy, from two different sites, one, leg vein and, two, the abdominal cavity?

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A. Yes. I think that we discussed that at the time but I am not sure.

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Q. To which of the samples did you understand the 72 nanogram level to be applicable?

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A. On March 20 when I discussed this with Dr. Ellis I knew I became aware at that time that it was the second one, the abdominal cavity sample was the one that they analyzed for digoxin, I mean, specifically analyzed for level because the first sample was so small that it had to be - it was all used up in the first test and simply was off the graph so they had to dilute - they would have had to ordinarily dilute it down in order to get another reading, an accurate reading. They used the second sample, the one that had been taken from the abdominal cavity, to dilute down and get an accurate reading.



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Q. Were you aware, in the first week of March, that the sample drawn from the leg, although not large enough to permit dilution, had itself recorded a level that was beyond the calibration of the equipment, greater than 4.7 nanograms. Did you know that, the first week of March?

A. No, I think I only knew the 72 figure, the final figure. I do not think I knew about - I know I did not know about all that dilution aspect of the case as to how they arrived at the 72. Dr. Ellis explained that to me on the 20th.

Q. And it was not until March 20th that you knew of the level recorded in the vein sample, then?

A. The level in the vein sample, yes, I found out about that on March 20 from Dr. Ellis, that it had been beyond the curve, the graph.

Q. On page 12 of the chart, the final paragraph of the pathological discussion again, the first sentence is:

"Samples of postmortem blood were obtained for assay of digoxin levels."

If you were focussing, Dr. Mancer, upon the sample from the abdominal cavity in which the 72-nanogram level had been recorded, can you tell me



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what you intended to convey by the use of the plural
"samples of postmortem blood were obtained" and "these
samples were contaminated" and so on?

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A. That is one of the reasons why I
think that Dr. Taylor probably wrote the first few
sentences of that. I know I added to this paragraph
and I think it is only the last sentence that I wrote,
but I am not absolutely sure.

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Q. But you do not recall making any
inquiry as to the use of the plural at the time the
autopsy was signed?

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A. I do not recall that.

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Q. I am interested then in the
second sentence of the paragraph:

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"These samples were contaminated
slightly by edema fluid and ascitic
fluid."

You have told us that Dr. Taylor had
described for you the method of obtaining the samples?

A. Yes.

Q. I take it we are now focussing
upon the sample from the abdominal cavity?

A. Right.

Q. Was it Dr. Taylor who volunteered
the information that the sample was contaminated



H.12

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slightly by the edema fluid and ascitic fluid or
did you ask him whether there was any contamination
there?

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A. Would you ask that question again?

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I am not sure I heard - I was trying to read.

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Q. Yes. Your sentence reads:

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"These samples were contaminated
slightly by edema fluid and ascitic
fluid."

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I asked you, is that information that
Dr. Taylor volunteered in describing his drawing of
the sample or was it information that he supplied
when you asked him whether the sample was a pure one?

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A. I think it was probably his
volunteering.

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Q. What did you at that time think
the effect would be of slight contamination by edema
fluid and ascitic fluid? Was that something that
went to your rejection of the recorded level?

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A. It may have entered into my idea
of rejection but I think I was thinking more of an
error in measurement rather than contamination, when
I rejected the 72 figure. It is possible that it
passed through my mind, but I can't really recall
specifically.



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Q I take it, even had it passed through your mind, you would have not, without a good deal more information, been able to say whether contamination would increase or reduce the recorded level in the sample?

A Yes. We just did not know as much about it - I did not know as much about digoxin then as I do now.

Q So contamination, in a sense, was a non-factor in your mind at that time because you did not know what effect it might have, even if there had been some contamination as far as the recorded level?

A Even now I am not sure what effect it would have.

Q Is there also the possibility of contamination by materials other than edema fluid and ascitic fluid in a sample drawn from the abdominal cavity, Dr. Mancer?

A Yes. On further consideration of that, there is, and that would include the water the pathology assistant uses when he washes down the body after the autopsy. The autopsy, of course, requires an incision in the abdomen which is sewn up, and then the body is washed after the completion of



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the autopsy with water. So there is a possibility
of water leaking into the abdominal cavity.

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Another thing that would be quite
important is that during the autopsy the rectum is
cut across and fecal contamination of the peritoneal
contents is also possible.

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Q. In any event, you have told us
now about your response to the information you
received at that time and we know now the paragraph
that was drafted either by you or by Dr. Taylor or
by the two of you to reflect that information?

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A. Yes, that reflects the information
that Dr. Taylor would have conveyed to me at the time
of the autopsy.

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Q. Could you turn with me to page
156 in the chart, Dr. Mancer. That is the first page
of the Biochemistry reports.

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Q. Now, the sample that is reported
there is, as we know, the abdominal cavity sample
recording a level of 72 nanograms. I am interested
in the manuscript notation on there "leg milked?"
Mainly gutter blood".

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Do you recognize that handwriting at all?

A. No, I do not.



H.15

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Q. If you would turn over two pages to page 158, Dr. Mancer, you will see the report from Biochemistry on the other samples recording a digoxin level of greater than 4.7. This is the sample which Dr. Ellis in his digoxin book has described as venous. Is this the sample you understand was drawn from the leg vein by the milking process that you have described?

A. Yes.

Q. This is the one about which you did not learn until March 20 - the level about which you did not learn until March 20?

A. I do not think I knew until March 20. It may have entered into our discussion at the time of the sign-out but I can't recall.

Q. When you learned of the 4.7 level, did you attach any significance to that measurement, Dr. Mancer?

A. It just means greater than 4.7.

Q. That is right.

A. It simply means greater than 4.7.

Q. Yes. You don't know how high up it may be?

A. No, we do not know any more than that.

Q. Did it serve to lend any greater



H.16

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credibility in your mind to the recorded level of 72
in the other sample?

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A. No.

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Q. We have talked about Dr. Taylor
obtaining that venous sample by milking a leg vein.
Can you tell me precisely what you understand that
to mean?

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A. One would elevate the leg and
then put a - in this context anyway.

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Q. Yes.

A. One would elevate the leg, put
a device to catch the blood as it comes through the
cut vein.

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Q. You would cut the vein to do this?

A. The vein would have already been
cut at the time of the autopsy, when the viscera are removed
so the iliac vein would be cut across and - it would
have been cut across during the autopsy, previously.



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Q. Yes.

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A. -- previously. One would

have to put a receptacle underneath the vein, and

then one person would be holding it there and the

other person would be elevating the leg and squeezing

from the ankle, proceed progressively towards the

upper thigh and trying to get as much blood as

possible out.

Q. And a receptacle would be

placed in order to ensure that such material as

was squeezed out of the veins didn't fall into the

abdominal cavity and be subject to the same

contamination I take it?

A. That is correct.

Q. So there would be a

collection of material coming directly from the vein

as I understand the explanation you have given to me?

A. Yes.

Q. Is that an unusual procedure

in your experience?

A. It sometimes has to be done

when somebody forgets to take a sample.

Q. And that sometimes happens too,

does it?

A. Well, it occasionally happens,



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yes.

Q. Now notwithstanding its unusualness Dr. Mancer, do you regard that as a satisfactory and acceptable way of obtaining a sample, if the necessity should arise to do it?

A. It is not a very satisfactory way. Only a limited amount of sample is likely to be obtained that way. There is also the possibility of contamination from the tissue around the vein, where the receptacle would be put against the pelvic wall. One is trying of course to get all the blood that comes out of the vein, but there would also be a little bit of leakage of fluid from around the vein actually. So one would not be getting entirely pure blood.

Then there is also the theoretical possibility that by squeezing the legs that one may be introducing something more into the blood vessels from the, from surrounding the blood vessels in the leg. So in that sense it is at least a theoretical possibility that the blood may be diluted by the tissue fluid.

Q. You mean material might penetrate the vein wall as a result of the massage or manipulation of the leg?



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2 A. Well capillary walls more
3 likely, small blood vessels, I mean small thickness
4 walls that is rather than larger veins where it
5 would be less likely.

6 Q. Are you aware of any studies
7 that demonstrate that that phenomenon may occur?

8 A. I am not aware of any studies,
9 it is simply logical.

10 Q. Logical that it could happen?

11 A. To my mind.

12 Q. Dr. Mancer, when you wrote
13 or approved the final paragraph of the pathological
14 discussion in the autopsy report, did you have any
15 opinion, or any concern as to whether digoxin may
16 have played a part in the death of Janice Estrella?

17 A. I thought that it was unlikely
18 to have. There were a lot of other findings in the
19 autopsy that would indicate that this was a very
20 ill child and could well have died. So I thought
21 that only if one could prove this level was really
22 accurate, then it might explain the death - I mean
23 it would explain the death rather than the findings
24 in the rest of the autopsy.

25 Like a patient with heart disease
can die at any time really and we wouldn't know whether



I-4

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- if a person had findings like Janice Estrella had, she might well have died at that time, or she might have lived a bit longer, she might have died a little bit earlier and the findings are essentially the same.

Q. Yes. But I take it against the possibility, however remote you considered it, that the level was an accurate level, you thought it proper to include the final paragraph in the autopsy report, is that fair?

A. Yes.

Q. Indeed Doctor, can we go a little further than that. The level did not need to be accurate in order to justify that prudence, did it. If it were only one-sixth accurate, it would still be a matter for some concern would it not? If the true level was 12, not 72?

A. Yes, well, that would be more believable.

Q. More believable, but just as troublesome would it not in terms of cause of death?

A. Yes. My knowledge of digoxin pharmacology at the time, I would have attached significance to a level of 12.

THE COMMISSIONER: You would have



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attached more significance to the 12 than to the 72?

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A. That is correct. Because 12, I mean a level of 12 is above the therapeutic range, high toxic.

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Q. Yes.

A. And at least in my mind at

the time it would have been hypoxic. We didn't know about changes post mortem at that time. I would have accepted the value of 72 as being - I mean, I would have accepted any value as being at face value.

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Q. Yes.

A. Because I didn't know that things changed post mortem with digoxin.

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Q. Except that 72 was so far off the scan that you attached no credibility to that number?

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A. That is correct.

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Q. Was it your intention Doctor in writing or approving the final paragraph of the pathological discussion, that if the recipients of the report had any concern about that recorded level they should follow it up?

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A. Yes, that would be my intention.

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Q. Did anybody from the Division



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of Cardiology follow it up with you?

A. Not with me.

Q. Or to your knowledge with anyone else in the Pathology Department?

A. No, not to my knowledge.

Q. Or to your knowledge with anyone in the Biochemistry Department?

A. Not to my knowledge.

MR. LAMEK: I am about to go to the reporting of the death Mr. Commissioner, it is one o'clock, is this sensible for lunch?

THE COMMISSIONER: Yes, all right, until 2:30 then.

MR. LAMEK: Thank you sir.

THE COMMISSIONER: Yes Mr. Hunt?

MR. HUNT: Can I make one comment just before we break?

THE COMMISSIONER: Yes.

MR. HUNT: It has to do with the letter that we were informed of yesterday that was sent to you by a representative of the Hospital dealing with that conference.

THE COMMISSIONER: Yes.

MR. HUNT: Mr. Scott kindly made available to all of us a copy of the letter to examine.



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While I don't have a photocopy of it I have had an opportunity to read it.

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As you are aware it certainly outlines the nature of the conference and the object of the conference insofar as digoxin is concerned.

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Now, it is clear to me from looking at the agenda that that conference is going to deal with issues that are of direct concern to this Commission.

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THE COMMISSIONER: Yes.

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MR. HUNT: And if I may say it strikes me that the public through this Commission has an interest in those issues insofar as they relate to digoxin itself and what is known and what is not known about it.

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Now, Mr. Scott has advised me that unfortunately the conference will be closed. While there is some thought that you as a Commissioner might be invited, that is not yet decided. It would appear that at the present time there is no intention to extend an invitation to any of the counsel on behalf of the parties withstanding before the Commission.

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In my view that is a great shame because of the very great concern that all of us here have with respect to the issues under consideration.



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Now Mr. Scott has explained to me the Hospital's feeling, or the organizer's feeling that the presence of any of us there may tend to restrict the debate, or the concerns that are expressed there, and the flow of information expressed there with respect to digoxin, and I appreciate that as a concern.

However, I would point out that it seems to me that we all have really the same interest at this point, and that is finding out as much as we can about what digoxin does and what it doesn't do, and how it reacts to the body.

My purpose in rising at this time is simply to indicate that I have an interest in attending at least the preliminary session of that conference. I don't know whether any of my friends do, but I would urge counsel on behalf of the Hospital to take up that question with their client with a view to seeing whether it is possible that there could be some rethinking of the question of our attendance at it, or some other arrangements made so that we can at least become aware of what is discussed in the preliminary sessions with respect to digoxin. I appreciate there is nothing you can do or anyone else can do.

I suggest that it would be, in light



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of the rather unusual nature of these proceedings
occurring at the same time and it would be something
that would be in everybody's interest.

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MS. THOMPSON: Mr. Commissioner I
will convey to Mr. Scott Mr. Hunt's concerns. I
believe that Mr. Hunt indicated they talked about
this issue yesterday. At this time I don't believe
we had any intention to reconsider because of the
academic nature of the workshop, but I certainly
will bring it to Mr. Scott's attention.

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MR. HUNT: Thank you.

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THE COMMISSIONER: Mr. Hunt, I have
not yet received an invitation. If I get one I
shouldn't say this ahead of time, but I will refuse.
I don't know that we can't make some sort of
compromise arrangement. I think clearly it would
destroy the conference if we all wanted to go.
That's all. So there is no possibility of that
happening. I don't know what can happen, but Miss
Thompson is going to discuss it with Mr. Scott and
perhaps he will let us know what the position is.

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MISS THOMPSON: Yes, Mr. Scott will
be attending the afternoon sessions today.

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THE COMMISSIONER: Yes, all right.
Thank you. Until 2:30.

--- Luncheon Recess.



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---On resuming.

THE COMMISSIONER: A lot of people were speaking to you in your absence just before the break. You have got all the messages, have you?

MR. SCOTT: I think so. I heard that Mr. Hunt wanted to be invited to the conference.

THE COMMISSIONER: Yes, but I suspect that everybody else wants to be invited and I suspect that that will be the end of the conference.

MR. SCOTT: Well, I wouldn't ascribe that capacity to Hunt to end the conference merely by an invitation.

THE COMMISSIONER: Well, at any rate, the wish has been conveyed and I guess you will speak to your clients and let us know what the story is.

MR. SCOTT: Yes.

THE COMMISSIONER: I don't particularly want an invitation but apparently everybody else does. Obviously from the letter it is perfectly clear to me that that can't happen but perhaps some kind of a compromise would be reached that would be satisfactory. I don't know what it is.

MR. SCOTT: Life being what it is, if you don't really want one, you will probably get one and everybody else won't. But I will enquire,



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2 Mr. Commissioner.

3 THE COMMISSIONER: All right. Yes,
4 Mr. Lamek?

5 MR. LAMEK: Yes, sir.

6 Q. Dr. Mancer, we had, just
7 before lunch, talked about the information that you
8 had at different times about the Estrella post mortem
9 digoxin level and your response to the information
as it came to you.

10 Now, we have heard that subsequently
11 on March 20th you reported the death of Janice
12 Estrella to the coroner?

13 A. That's correct, yes.

14 Q. Can you tell us please how
did that come about?

15 A. Dr. Cutz came to my office
16 and told me that he had an unusual result on one of
17 his autopsy cases and told me about the high digoxin,
18 and that was the Pacsai case.

19 Q. Dr. Cutz had performed the
20 autopsy on the Pacsai child?

21 A. That's correct.

22 Q. Had he had any part in the
drawing of samples for digoxin assay on Pacsai?

23 A. Yes, he did.
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Q. Okay. That was a death that
had been reported to the coroner?

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A. That's correct.

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Q. At or about the time it
had occurred because of the father's reaction to the
child's death, as I understand it and as we have heard
here?

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A. That's my understanding as
well.

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Q. And therefore it being a
coroner's case I take it that in that case the autopsy
was performed by Dr. Cutz himself rather than by a
resident whose work would be overseen by Dr. Cutz?

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A. Yes, that is right.

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Q. But it is the practice in
the hospital I understand that in coroner's cases the
inquests are performed by the staff pathologists
themselves?

A. The staff pathologists do
the autopsies, yes.

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Q. I'm sorry, the autopsies are
conducted, yes. We have heard the information as to
the Pacsai digoxin levels became available on March
the 18th, at least that was the day upon which Dr.
Carver learned of them and through him Drs. Fowler



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and Rowe. Was it on the 20th that Dr. Cutz came to
you?

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A. Yes.

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Q. Did you have the understanding
that it was his expressed purpose in coming to you
to tell you about that digoxin level in Pacsai?

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A. I believe it was, yes.

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Q. All right. And did he tell
you what the level was?

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A. Yes.

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Q. What was it, do you recall?

12

A. 26.

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Q. 26. And upon receiving that
information, what occurred to you, Dr. Mancer?

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A. Well, now, the Estrella case
with its level of 72 assumed new importance to me.

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Q. Are you suggesting that
with the Pacsai information you could no longer
afford to assume the invalidity of the Estrella
reading?

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A. That's right. Even the
26 is very very high and one would even question
that. But now that we had another case, the Estrella
case took on new importance to me.

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Q. Yes. And did you then call



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the coroner?

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A. Yes, I did.

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Q. Did you make any further enquiries or obtain any information before calling the coroner?

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A. Yes, I actually put in a call to the Coroner's office to have Dr. Tepperman call me and I realized that it would take a while for that to happen, so, for him to get back to me and I asked that my secretary divert the call to Dr. Ellis' office because Dr. Cutz had mentioned that he had got the results from Dr. Ellis and implied I should call to Dr. Ellis.

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Q. Now, you referred to Dr. Tepperman. I take it that you were aware that Tepperman was the coroner to whom the Pacsai death had been reported?

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A. Yes. I had asked Dr. Cutz who was the coroner on his case.

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Q. And you chose to report the Estrella death to that same coroner?

A. Yes, I did.

THE COMMISSIONER: Excuse me just a moment. You said to divert, that is, you wanted the coroner to speak directly to Dr. Ellis?



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2 THE WITNESS: No, I wanted him to
3 speak to me and I would be at Dr. Ellis' office.

4 THE COMMISSIONER: Oh, I see.

5 MR. LAMEK: Q. So, while awaiting
6 a call from Dr. Tepperman you went to Dr. Ellis'
7 office?

8 A. Yes.

9 Q. And what did you discuss
10 there with him?

11 A. I found Dr. Ellis reading
12 the chart on Estrella and he had all the data on
13 Estrella and Pacsai there and I discussed with him
14 the high levels and I satisfied myself that they
15 must mean something.

16 Q. All right. Had you forewarned
17 Dr. Ellis of your arrival on the 20th?

18 A. Yes.

19 Q. Did you call ahead to find
20 out if he was there?

21 A. No, I went straight to his
22 office; I don't think I did anyway.

23 Q. And you found him reading
24 the Estrella chart?

25 A. Well, he had it with him and
he was going over the data on both Pacsai and Estrella.



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Q. All right. Did you tell him that it was that very connection that brought you to his office?

A. I suppose so. I can't recall exactly what I did.

Q. Did he make any comment to suggest to you that he too had made the same connection that you had made between the Estrella and the Pacsai numbers?

A. Well, he obviously had, going over the charts. I don't remember any comment.

Q. And how were you able to satisfy yourself that you had to pay attention to the Estrella recorded level?

A. Well, because the Pacsai level was so high I would have questioned the Pacsai level too if it had been in isolation.

Q. Yes.

A. But with the two of them being up to ranges that I wouldn't have thought possible under therapeutic circumstances, and that was what I was thinking of.

Q. Yes.

A. I had no reason to think otherwise. It became apparent that we had to pay



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attention to both these levels.

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Q. All right. Did you have any discussion at that time with Dr. Ellis about the suspected contamination of the Estrella sample which had yielded the 72 nanogram measurement?

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A. I don't know that I did have any discussion about contamination, I can't recall about that.

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Q. All right. Was it in the course of that conversation with Dr. Ellis that you learned of the second sample, the venous sample which had recorded a level of greater than 4.7 nanograms. You told us that you learned that on the 20th.

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A. Well, I must have because Dr. Ellis went through his whole work-up of the specimen at the time and he would have told me that on the 20th.

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Q. Prior to that conversation with Dr. Ellis had you been aware of the procedure whereby the assay readings were calibrated up to 4.7 or 5 nanograms and beyond that one had to dilute a sample in order to get an actual reading?

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A. I didn't know that that was how they did it.

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Q. Was that explained to you

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2 by Dr. Ellis on the 20th?

3 A. Yes.

4 Q. And did you then understand
5 that the Estrella level had been the result of not
6 one run through the assay but of several runs through
7 representing different levels of dilution?

8 A. Yes.

9 Q. Was that one of the matters
10 that persuaded you that lab error as an explanation
11 for that number was an unlikely explanation, the fact
12 that the procedure was repeated so often?

13 A. That probably contributed to
14 it. I'm not sure that that was the only explanation.

15 Q. No, I said was that one of
16 the things?

17 A. I think it is one of the
18 things, yes.

19 Q. Do you recall what the other
20 elements were. You have told us of two; one, the
21 very presence of the second high reading and, two,
22 your then understanding that the 72 reading was a
23 result of repeated assays on ever greater dilutions.
24 What other factors contributed to your being satisfied
25 that the Estrella number was something to be contended
with?



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A. The Pacsai level?

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Q. The Pacsai level, yes.

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Anything else?

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A. As far as I know that's

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the only thing, sir.

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Q. All right. Do you recall

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anything else of your conversation with Dr. Ellis
that day?

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A. Yes. We had also talked

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about the possibility that tissue may release digoxin

11

and something that I had been unaware of before,

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that the heart has a very high digoxin level as
compared to blood.

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Q. Yes.

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A. Dr. Ellis was aware of that

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and he was aware of the possibility - I'm not sure

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whether he knew it from some publication that he had

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read or whether it was logical to him that there may

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be some release of the high quantity of digoxin

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in the heart muscle after death and that this may

20

artificially raise the level of digoxin in the

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blood. So that the post mortem level would not
really reflect the antemortem level.

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Q. All right. It may not be

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one on one with the immediate antemortem concentration?

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A. Yes.

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Q. All right. And that appeared to be something with which Dr. Ellis had some familiarity or some awareness?

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A. Yes, he had some knowledge.

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Q. Do you recall anything else that was discussed with Dr. Ellis that day?

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A. Well, I know we talked about how this could have happened and Dr. Ellis said maybe there is somebody on the ward that can't multiply properly.

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Q. Did you take him to be suggesting some mistake in administration?

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A. Yes, that's what I thought.

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Q. Or in prescription perhaps, can't multiply properly?

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A. Well, no, we didn't talk about prescription.

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Q. All right. And what was your contribution to the discussion of how this could have happened?

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A. I listened to his idea about the release from the heart and thought it did seem logical in the sense that tissues do break down after death, membranes around the cells break down and what

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2 is in the cells can come out. So, it did make sense
3 from a pathologist's point of view.

4 Q. Did you at the end of your
5 conversation with Dr. Ellis on the 20th suspect that
6 the deaths of these two children, that is to say,
7 Pacsai and Estrella had been caused by digoxin
8 intoxication?

9 A. Yes, as a result of that
10 conversation that thought certainly suggested itself.

11 Q. And had you gone any
12 further in your thinking along that line as to the
13 way in which the digoxin intoxication may have come
14 about, how the amounts of digoxin apparently taken
15 in by these two children may have been administered.
16 Had you begun bluntly to contemplate the possibility
17 of something sinister happening in the case of those
18 two children's deaths?

19 A. Not really until I talked
20 to Dr. Tepperman. At that point when he answered the
21 call I was still in Dr. Ellis' office.

22 Q. Yes.

23 A. And then he brought up
24 the possibility that there may be something - it may
25 not be just an error but there may be something
sinister.



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Q. What did you tell Dr. Tepperman when he called?

A. I told him that I was aware that he had the Pacsai case in which there was a level of 26 and that we had another case which had recently signed out with the resident in which the level was 72 and I thought that it should be him that should know about this rather than anybody else so that he could make the connection just like we did, Dr. Ellis and I.

Q. Sorry?

A. Just like Ellis and I did.

Q. Okay. Did you at that time explain to him that the child whose death you were now reporting had died some two months earlier?

A. I would have told him that.

Q. And explained to him the reasons for not having attached any significance to the digoxin information at an earlier date?

A. Yes, I told him about my reservations about the level in the Estrella case and in the Pacsai case too in reflecting on the Pacsai data - I'm sorry, reflecting on what Estrella - on what Ellis said to me about the release post mortem of digoxin from the heart muscle.



(Lamek)

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Q. Yes.

A. And Dr. Tepperman said that he didn't think that was a factor in the Estrella case - in the Pacsai case because he had both an antemortem and a postmortem which are comparable.

Q. Yes.

A. So, that made he and I attach more significance to the Estrella case.

Q. All right. When you told Dr. Tepperman Dr. Ellis' information about the post mortem release of digoxin from tissue and, in particular from the heart, did that appear to come as news to Dr. Tepperman or did it appear to be something with which he was familiar?

A. He didn't comment, so, I couldn't really tell you.

Q. Okay. Did you tell him of your concern about the possible contamination of the Estrella sample?

A. I can't recall.

Q. Did you tell him at that time of the second reading of greater than 4.7 nanograms in the sample of venous blood taken from Estrella?

A. I can't recall specifically.



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2 Q. Now, you have told us then
3 that the conversation with Dr. Cutz which prompted
4 you to make the connection between Estrella and
5 Pacsai and of the conversation that you had with Dr.
6 Ellis after having placed a call to Dr. Tepperman.
7 Other than your first conversation with Dr. Cutz
8 did you consult with anyone in the hospital before
9 you placed the call to Dr. Tepperman to try to reach
him to report the Estrella death?

10 A. No. I only made instructions
11 to my secretary to relay the call.

12 Q. To forward the call?

13 A. Yes.

14 Q. And you didn't tell anyone
15 that you were going to report that death I take it?

16 A. No. Well, I think I probably
told Dr. Cutz.

17 Q. Dr. Cutz.

18 A. Or implied to Dr. Cutz.
19 Certainly I asked him who the coroner was and I
20 probably told him of my intent to report it.

21 Q. Now, having reported the
22 death, and I take it that took place in the presence
23 of Dr. Ellis who was there when the call came in
24 I think?
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A. Yes, he would have heard the conversation I would think.

Q. Having reported the death of Estrella to Dr. Tepperman, did you then tell anyone or report to anyone at the Hospital what you had done and why?

A. No, I left it in Dr. Tepperman's hands.

Q. All right. From the time that you delivered the final autopsy report in the Estrella case in the early part of March, 1981, when was the first time after that that you can recall any staff cardiologist at the Hospital speaking to you about the Estrella death?

A. It wouldn't be a direct statement but at the meeting on the following Tuesday morning cardiologists were present and I was asked about the reporting of the Estrella death. So, they would have heard what I said.

Q. All right. That was a meeting with police officers?

A. Yes, police officers were there.

THE COMMISSIONER: This is the Tuesday following the release of the report, is that



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right?

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THE WITNESS: No, this was the ---

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MR. LAMEK: I think Dr. Mancer is
referring to Tuesday the 24th of March.

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THE WITNESS: That's correct.

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THE COMMISSIONER: Okay.

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MR. LAMEK: Q. Now, I don't want
to get into that meeting.

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THE COMMISSIONER: This report though
was ---

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MR. LAMEK: Well, again, it is
undated, Mr. Commissioner, but Dr. Rowe's evidence
you will recall that he saw it, brought to him by
Dr. Fowler in the second week of March, which would
be consistent with Dr. Mancer's recollection.

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THE COMMISSIONER: Apparently Dr.
Mancer says it seems to be signing out on March
3rd to 6th, isn't that right?

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THE WITNESS: Yes.

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THE COMMISSIONER: But it wasn't
the Tuesday following that?

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THE WITNESS: No, it was the Tuesday
following the reporting of the Estrella death.

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THE COMMISSIONER: All right.

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MR. LAMEK: Q. And then if I

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understand you correctly, Dr. Mancer, it was not so much a staff cardiologist speaking to you about the Estrella case but rather your speaking about the Estrella case at a meeting which was attended by some of the cardiologists?

A. That's correct, yes.

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Q. I said I had three matters that I wanted to ask you about, Dr. Mancer, and the second is related to that one and it goes to the question of possible contamination of the gutter blood sample or the abdominal cavity sample, from Estrella.

You, in the final autopsy report, had drawn attention to the slight contamination which had apparently occurred with respect to that sample. I suppose it is fair, is it not, that a legitimate question was whether there was any reliable correlation between digoxin concentrations in gutter blood and those in antemortem circulating blood?

A. Yes.

Q. Or even between postmortem samples in gutter blood and postmortem samples from the venous system?

A. Yes.

Q. I understand that a study was undertaken by the hospital and the Centre of Forensic Sciences on that very question, was it not?

A. Yes.

Q. And you were involved in the setting up of the study, as I understand it?

A. That is correct.

Q. This occurred some time after the



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events that we have just been discussing, sometime in
the late summer and fall of 1982, as I understand it?

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A. That is correct.

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Q. But nevertheless it does bear
upon the meaning of the Estrella sample?

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A. Yes.

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Q. I suppose we can therefore
discuss it now.

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As I understand it, Dr. Mancer, you were
involved in setting up what I believe is called a
protocol for the obtaining of samples at autopsy for
digoxin assay for the study?

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A. Yes.

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Q. And the study was designed to
see, over as large a number of samples as possible, I
take it, whether indeed there was a discrepancy that
could be detected between gutter blood digoxin
concentrations and concentrations in the blood taken
from the blood vessels of the venous system and
arterial system?

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A. Yes.

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Q. I am showing to you, Dr. Mancer,
two documents, the first of which is dated August 24
of 1982 and the second of which is undated and they
are, as I understand it, two versions, or a version and



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a refinement, of the protocol that you devised, I take it, in consultation with Mr. Cimbura at the Centre of Forensic Sciences for the obtaining of samples for the purpose of the study?

A. Yes.

Q. Are those the two documents, and they bear your signature?

A. Yes.

MR. LAMEK: Perhaps those could be marked together as the next exhibit, Mr. Commissioner.

THE COMMISSIONER: Should they be separated in any way - the dated one 202A and the undated one 202B.

--- EXHIBIT NO. 202A: Document dated August 24, 1982 re protocol for obtaining of samples re digoxin study.

--- EXHIBIT NO. 202B: Undated document re protocol for obtaining of samples re digoxin study.

MR. LAMEK: Q. Dr. Mancer, as I understand it, from some date considerably earlier than August 24th, 1982 the practice had been followed of taking samples at autopsy from children who had died on the cardiology wards for digoxin assay.

A. I believe that we have been taking samples on all hospital deaths for digoxin assay



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right from the --

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Q. The last week of March of 1981?

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A. Yes, and it still continues.

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Q. But what the two documents that we now have add, as I understand it, is a protocol for the taking of samples for the particular purpose of the gutter blood study. Is that so?

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A. Yes.

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Q. I take it that the purpose of the exercise was to replicate, as far as possible, the circumstances of the drawing of the Estrella samples?

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A. That is correct.

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Q. And therefore samples were to be taken at two points in time, one at the start of the autopsy, which was not of course a replication of the Estrella situation?

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A. Yes.

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Q. And there, among the samples to be drawn, were item number 7, and I am looking at Exhibit 202A, the document of August 24, which required the milking of blood from the proximal femoral vein and the distal leg vein of one leg and, 8, a sample of the fluid that leaked into the pelvic cavity, gutter fluid. Then, three hours later, three hours after the start of the autopsy, the milking of blood from the proximal



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femoral vein and distal leg vein of the other leg.

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Why the other leg, please, why not from
the same leg?

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A. The Estrella case, there had
been no milking of blood at all, so that situation
would duplicate the Estrella case as closely as
possible, to do it from the untouched leg.

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Q. I see, okay. And three hours
later, because I take it in the case of Estrella the
samples had been obtained, I think Dr. Taylor's
evidence was about a half an hour after the end of
the autopsy --

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A. Yes.

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Q. -- and three hours I take it was
intended to approximate the lapse of time from the
beginning to the end of the autopsy, the removal of
the body and the additional period before which Taylor
went and took his samples?

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Q. And the samples, after having
been drawn, were to be appropriately labelled of
course and sent to the Centre of Forensic Sciences.

22

Were all the assays done at the Centre
on the samples?

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A. Yes, all except parts of the



1
2 protocol where it says some may be sent to the HSC
3 lab if over 2 ccs. We wanted to make sure that the
4 Centre of Forensic Sciences got blood and the
5 biochemistry lab at Sick Children's would get some
6 if there was some available.

7 Q. Exhibit 202B, Dr. Mancer, which
8 appears to be a revision of the protocol, as far as I
9 see, differs in one material respect with regard to
10 the gutter blood study and that is that in stage B,
11 three hours after the start of the autopsy, blood is
12 to be milked from both legs; one, I take it, for the
13 sake of duplicating the Estrella situation and the
14 second leg is to have a sample drawn from it at that
15 point, but also you have a three hour interval between
16 the two venous samples from the same leg in this second
17 protocol.

18 I take it that may allow you to see what
19 changes there may be in the level in that intervening
20 three hour period?

21 A. Yes.

22 Q. Finally, one of the other things
23 that is added is under the notes at the bottom, number
24 3, the age, the weight, the sex, the
25 doses history, the amount given, the last dose, the
time of death and the time of autopsy are all to be



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provided with the samples and there had been no expressed requirement that that information be given under the earlier protocol?

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A. That is correct.

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Q. To the best of your information, Dr. Mancer, was it the revised undated protocol which was followed for the purposes of the gutter blood study?

9

10

A. Yes. I gave instructions to destroy the old copy and use the new one.

11

12

13

Q. Other than preparing the protocol for the obtaining of samples at autopsy, did you participate in any other way in the gutter blood study?

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A. No. I designed it and Dr. Phillips, the Chief of Pathology, received the data.

17

18

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Q. You did not receive copies of the results obtained in the samples drawn under this protocol?

20

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A. No.
Q. I suppose we'll have to ask Dr. Phillips and Mr. Cimbura about those.

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Having moved to the third of the topics, Dr. Mancer, we have heard that in the very early days



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of the police investigation, and that is a matter in which in its broad scope we are going to be coming to much later in this Inquiry, in the very early days the Pathology Department in the hospital was provided with a list of names and that is the list that has been marked as Exhibit 197, Mr. Commissioner.

I am showing you a copy of that list, Dr. Mancer. Do you recall receiving or seeing such a list?

A. I cannot specifically recall the way in which we received this list.

Q. Do you recall that you did receive it?

A. I extrapolate from the list I made - I must have been working from this list, but I cannot specifically recall this list.

Q. The more important document is obviously the one that was prepared in the Pathology Department. It is our Exhibit 198. I show you a copy of that. Is that the document to which you have just referred as being the one that "we" prepared?

A. That is correct.

Q. Because of the coincidence of not only the names but the sequence of their listing you infer that Exhibit 198 was prepared with Exhibit



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197 in hand?

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A. That is correct.

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Q. I give you copies of that.

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A. Thank you.

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Q. What were you required or asked

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to do with respect to each of the children whose names
are listed on the two sheets, Dr. Mancer?

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A. Well, Dr. Cutz and I attended

9

the meeting of Tuesday, the 24th of March, 1981, and

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it was after that meeting that we did the work that

11

led to this list. We were under the impression that

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the police had asked for the reports as soon as

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possible, and we thought that actually they would be

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back the next day to the meeting that was called for

15

the next day.

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Q. I take it from the way that was

framed that they were not?

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A. That is correct.

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Q. As to the whys and wherefors

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of that, we are not presently concerned, but you had

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the information prepared for the following day?

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A. Yes. The nature of the meeting

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on the Tuesday involved a lot of questions about the

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digoxin levels on the basis of very little information

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so we tried to put as much information on the table as

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possible so that the people at the meeting could discuss it.

Q. Were you asked to provide information as to, a, diagnosis and, b, cause of death? I know that is what you did provide. Was that what you were asked to provide?

A. We were asked to complete reports, I know that.

Q. When you say complete reports, what do you mean by that?

A. Many of the final reports of these patients that are on this list were not complete as of March 24 in the morning and between the morning of the 24th and the morning of the 25th, we, Dr. Cutz and I, and Dr. Becker, finished all of these cases off and provided the complete reports. That included cases that were supervised by Dr. Phillips, who was away at the time.

Q. Let me be sure I understand. Let us take the case that was yours. We know Estrella was yours. Which of these other cases were yours, Dr. Mancer?

A. I cannot recall specifically.

Q. All right, we know that the Estrella report had already been done as of March 24th



BB 11

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so that was not one that need to be completed?

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A. Yes.

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A. That is my understanding, yes.

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and Dr. Becker set about to do from the 24th to the

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A. Right.

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Q. To complete the write up of
those reports ready for sign-off?

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A. Yes.

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Q. From that information, so
prepared, Exhibit 198, I take it is a dissertation
setting out the primary diagnosis - I take it this
are the pathological diagnoses rather than the
clinical diagnoses - of Hines, for example, there
had never been a clinical diagnosis of death. That
had to be a pathological diagnosis, did it not?

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A. Yes, I believe that is right that
these are probably the pathological diagnoses.

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Q. I take it the cause of death is
a statement of opinion based upon all the information



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available, clinically and pathologically?

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A. Yes, at that time.

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Q. Then available?

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A. What seemed reasonable is what we put down as the cause of death.

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Q. Other than looking at the notes made at autopsy, the draft reports in whatever state they then were and the charts, what other sources of information did you use, Dr. Mancer, in compiling Exhibit 198?

10

11

A. We used the information that was available on digoxin.

12

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Q. The Biochemistry Department results?

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A. Yes.

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Q. Anything else that you can now recall?

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A. You mean to make these statements that we have on the cause of death?

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Q. Yes, and on the diagnosis.

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A. Simply the milieu in which this was occurring. We had several cases on which there were known high digoxin levels and in these cases that are listed as undetermined we would consider them as possibly in that category of high digoxin, if we had

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Mancer, dr.ex.
(Lamek)

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BB 13

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blood to analyze. We were really putting a question
mark beside those cases.

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Q. Now, we have heard from Dr.

Becker, who has told us as I recall his evidence, Dr. Mancer, that he did not participate directly in the preparation of the document which is now Exhibit 198.

A. Yes. I believe this was only Dr. Cutz and myself that prepared this table.

Q. And in preparing the table, to the extent that it related to cases of Dr. Becker's, did you talk to Dr. Becker, or did you merely look at the chart and the pathology reports?

A. I can't recall whether I talked to him, or Dr. Cutz talked to him, or not.

Q. Of course, one of the significant cases that Dr. Becker had in that period was that of Jordan Hines?

A. Yes.

Q. And you have listed the diagnosis with respect to Jordan Hines as: "Query crib death and bradycardia". Before we come to the cause of death column, what was the source of your information as to: "Query crib death and bradycardia" as diagnoses there?

A. Well, I think crib death probably came up in the autopsy report.



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Q Would it assist you to see the
autopsy report?

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A. Yes, I think it would.

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MR. LAMEK: That is Exhibit 103,
Mr. Commissioner. Mr. Registrar, could we have the
Hines chart, please, for Dr. Mancer.

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Q You will find the autopsy report,
Dr. Mancer, at page, the preliminary autopsy report
at page 28, it did not change at all in its trans-
lation from a preliminary to final?

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A. Yes. The title of it I notice
is "Query Sudden Infant Death Syndrome", and the
statement: "Query crib death", it is really synonymous.

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Q Did you understand from a reading
of the autopsy report in the Hines case that the
diagnosis of Sudden Infant Death Syndrome was a
tentative one?

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A. Well actually this page 28, this
is the preliminary, where is the final?

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Q It is not in the chart, it is
filed separately, Doctor, but I promise you there is
no difference in the text.

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A. I see.

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THE COMMISSIONER: Would you just hold
it up, Doctor, for a moment, because I think - behind
that document right there at the end.

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MR. LAMEK: No, that is the zebra pack.

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THE COMMISSIONER: Well, 103A should be there. Something has happened to it?

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THE WITNESS: It still says: "Pathological diagnosis Query Sudden Infant Death Syndrome".

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MR. LAMEK: Q. My question, Dr. Mancer was, did you understand that to indicate that the diagnosis of Sudden Infant Death Syndrome was a tentative one, one of which Dr. Becker was less than completely convinced?

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A. That is the way I would interpret it if I saw this document.

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THE COMMISSIONER: But you said, oh, I am sorry, you were looking at page 2 where it says "Query Sudden Infant Death Syndrome", that is the pathological diagnosis.

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MR. LAMEK: Yes.

Q. And that was reflected in the paper that you and Dr. Cutz compiled as "Query crib death"?

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A. Yes.
Q. Now the cause of death you show as undetermined there. Can you tell me why you regarded the cause of that death as undetermined in light of the information that was available to you?



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A. Well, since we had other cases in which digoxin was high, known to be high, and we had a case here that was signed out as: "Query Sudden Infant Death Syndrome", a tentative diagnosis. Since Sudden Infant Death Syndrome is a diagnosis really of exclusion, one really should exclude everything else before calling it that, and now we have another possibility. So that is why we used the word "undetermined".

Q. Not that there was evidence on the face of the Hines chart, or information, to suggest any other cause, but the whole climate was perhaps suggestive of a possible other cause, is that fair?

A. That is correct.

Q. I take it that does not suggest, Dr. Mancer, that you rejected Sudden Infant Death Syndrome as a possible cause of death also, that could also have been a possibility?

A. Yes.

Q. But does it mean this: I think I understand what you tell me correctly. In light of the events of the preceding days and weeks, where there was a death which was not readily and obviously explainable on the face of the medical and pathological



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information, you recognize there had to be a question
as to the cause of that death?

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A. Yes. I think really I would
put it down to preceding days rather than weeks,
because in early March it was a different, you know ---

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Q. Yes, of course. We are really
dating this from the report, or your learning of the
Pacsai dig. levels.

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A. Yes.

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Q. By the time we got to the
compilation of this document you had that piece of
information; you had reassessed the weight that might
have to be attached to the Estrella level; you had
heard of the Miller levels which were very high; and
you have listed Cook as digoxin overdose. I take it
at the time of this compilation you had some infor-
mation that there was an inordinate level of digoxin
found in Justin Cook?

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A. Yes. Dr. Cutz was the pathologist
that was involved with the Miller and Cook cases. He
probably was the originator of that information on
the bottom two lines, and so it would probably be
best that he gives that.

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Q. Let's go to the top though, to
your own case, Estrella. There the cause of death



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is uncategorically stated, although I know it is a
summary of simplification.

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A. Yes.

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Q. Boldly stated it is digoxin over-
dose?

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A. Yes.

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Q. Do I take it from that, Dr. Mancer,
that by the date of the compilation of Exhibit 198,
which was March 24th or 25th, you were satisfied that
Janice Estrella had probably died of a digoxin over-
dose, was that your view then?

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A. Well, that seemed a reasonable way
in which to interpret the Estrella case, all the data,
and when one correlated it with what else was going
on with other cases.

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Q. Okay. You had come to that
conclusion, that probable conclusion as at March 24th-
25th, notwithstanding the doubts that you had
earlier entertained about the validity and reliability
of the digoxin level recorded post mortem on that
child?

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A. That's right.

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Q. I want to understand the process,
Dr. Mancer, because I think it to be important. Was
it your view, as indeed it had been in the early days



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of March, that looked at in isolation the Estrella death and the digoxin level could properly be regarded, or were regarded, as an aberration as far as the level was concerned, and an unsuspicious death as far as the death was concerned?

A. That is correct.

Q. Looked at in isolation.

A. Yes.

Q. But when you put it into the context of what was occurring from the 20th of March onwards, then a very different picture of that death was emerging for you, was it not?

A. Yes.

Q. And indeed long before March 24th a different picture of that death and that level had occurred to you, as early as March the 20th when you had just one additional piece of information, the Pacsai dig. level?

A. That is correct.

Q. And everything that occurred from March the 20th to the 23rd only served to fortify that overall picture that led you to reassess the Estrella death?

A. Yes.

Q. Is that fair?



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A. Yes.

Q. Is that fair?

A. Yes.

Q. A couple of other questions quickly about Exhibit 198 if I may, Dr. Mancer.

The case of Kristin Inwood, the fourth from the bottom, again shows the diagnosis of coarctation of the aorta, congestive heart failure, the cause of death as undetermined. Does that categorization suggest that in the then prevailing climate you were not satisfied, or convinced, that the pathological findings fully explained that death?

A. I think Dr. Cutz is the pathologist that was responsible for the final report on Inwood. Although he didn't supervise the autopsy originally. I know from discussions with him that he signed out that case, and it probably would be better to ask him why undetermined is written in, I would just be giving my own interpretation.

Q. As far as Inwood is concerned, obviously we have to ask Dr. Cutz himself?

A. Yes.

Q. But when the word "undetermined" was set in the cause of death column in this document of which you were a co-author, what did you understand it to mean?



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A. That that is one of the cases that we would think about fairly strongly as being a possible overdose.

Q. As opposed I take it to the cases of Thomas and Warner, the third and fourth on the sheet. I take it the categorization of death is natural and I take it you were satisfied that the death was caused by the findings that are disclosed in the diagnosis column?

A. Yes. We must have been very strongly convinced in those cases.

Q. And then there appears to be a middle ground, as in the case of Charlon Gardner, the third from the bottom whose cause of death is described as "probably natural". Is that falling half way between being totally convinced that the death was a natural one, but a niggling doubt that there may be something to be looked at?

A. Yes, I think that is correct.

Q. And other than the climate that was prevailing in the week of March 23rd when this document was prepared, was there any other basis for your categorization of the Hines and Inwood deaths as "undetermined", and the Gardner death as "probably natural". Was there anything in particular that you



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could recall in those charts that raised a possible question? Would it be of assistance to you to see the charts?

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A. We probably should. I can't recall the cases themselves.

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Q. Do you recall if any of them were yours? Hines we know was Dr. Becker's case, and Inwood was the case of Dr. Cutz, that he took charge of?

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A. Yes.

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Q. And Gardner?

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A. I think Gardner was Dr. Phillips' case, but I signed out in his absence. I believe Thomas was my case, but I am not sure of that.

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Q. Thomas you didn't have a question about?

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A. Warner might have been my case, I can't recall.

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Q. And again there is no question. Well, Doctor, if it should become important you can take a look at the chart, I don't conceive it would be very important. We have the catheterizations you made at that time.

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MR. LAMEK: Those are my questions, thank you very much.

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THE COMMISSIONER: Yes. Thank you,



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Mr. Lamek. Mr. Scott?

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MR. SCOTT: Can we take our break right

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now?

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THE COMMISSIONER: All right, we will

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take 15 minutes.

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--- Short recess

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--- Upon resuming:

THE COMMISSIONER: Yes, Mr. Scott.

EXAMINATION BY MR. SCOTT:

Q Dr. Mancer, you told my friend Mr. Lamek that in a case where the coroner is -- I'm sorry.

MR. LAMEK: I'm sorry, would my friend forgive me. Because of scheduling problems, Mr. Commissioner, could I get some idea please of how long the cross-examination of Dr. Mancer is likely to take? Could we do a quick head count of counsel, please.

MR. SCOTT: Half an hour.

MR. LAMEK: You'll be half an hour?

MR. SCOTT: Yes.

THE COMMISSIONER: Miss Chown?

MS. CHOWN: Very briefly, about five minutes, Mr. Commissioner.

THE COMMISSIONER: How much?

MS. CHOWN: About five minutes.

MR. BROWN: Ten minutes perhaps.

MS. FORSTER: Ten minutes.

MR. HUNT: Ten, fifteen minutes.

MR. YOUNG: We have no questions at the present time but we are interested in hearing



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what Mr. Scott has to ask.

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THE COMMISSIONER: All right, Miss

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McIntyre?

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MS. McINTYRE: Ten minutes if any.

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MS. JACKMAN: No questions at the present.

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MS. WHARTON: No questions.

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MR. OLAH: About 15 minutes, Mr.

Commissioner.

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MR. LABOW: About 15 minutes, Mr.

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Commissioner.

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MR. TOBIAS: I would think about 10

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minutes, Mr. Commissioner, depending on what Mr. Scott comes up with.

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MR. SHINEHOFT: Ten minutes, Mr.

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Commissioner.

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MR. LAMEK: Thank you, that is certainly very helpful.

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THE COMMISSIONER: We certainly would

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finish tomorrow morning if everybody is honest.

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MR. LAMEK: Thank you very much. I

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apologize to Mr. Scott.

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THE COMMISSIONER: All right.

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MR. SCOTT: Q. Dr. Mancer, you have

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told -- to keep myself honest I've got to move right along now. You have told my friend --

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THE COMMISSIONER: Or you can drag it
out for half an hour.

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MR. SCOTT: You're cutting into my time.

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Q. You have told Mr. Lamek that
where the coroner is called and your Hospital performs
the autopsy, that the autopsy is done by a pathologist
in those cases rather than by a resident?

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A. That's if the coroner gives us a
warrant to perform a medical/legal autopsy.

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Q. Yes. Now, will you tell us whether
there are any differences between an autopsy that is
done at the request of a staff member of the Hospital
with the consent of the parent on the one hand and an
autopsy that is performed either under a warrant or
in some fashion at the request of a coroner for
medical/legal purposes?

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A. Yes, the medical/legal autopsy
requested, that is given in which we get a warrant is
one in which the autopsy is directed to finding a
specific cause of death. The hospital cases are more
to correlate the clinical course of the patient with
the autopsy findings and explaining any discrepancies
but not necessarily to find the cause of death. One
may find the cause of death in them, but the cause
of death may be so complex as to be very debatable.



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They are usually more complicated cases.

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Q The non-coroner cases?

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A The non-coroner cases, yes.

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Q All right. And therefore in a case where you are doing an autopsy for a hospital clinician with the consent of the parent, can you just tell me what the focus of your inquiry is?

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A Well, it is to find all the diagnoses that are apparent at autopsy and then we correlate that list of diagnoses that we make with what was known about the patient before death. That is usually what is known about it is a very précised capsule summary of what was in the chart as read by the resident in pathology.

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Q Well now, in this Inquiry we have had evidence of both preliminary autopsy reports and final reports. What is usually the difference between those two documents?

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A Well, the preliminary report only includes the gross findings, that is, what one can see with the naked eye at the time of autopsy. The preliminary report also has the brief summary of the patient's clinical course after the resident has read the chart. The final report includes the microscopic examination which may add diagnoses or may change diagnoses that were on the preliminary report.



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Q. Does it follow from that that the preliminary report will often come though perhaps not always be done before the arrival of the microscopic results?

A. Yes, ordinarily it would be.

Q. Yes. And in microscopic results do we include now postmortem digoxin readings?

A. Well, that would be other data other than microscopic, like, any postmortem toxicology, postmortem bacteriology, virology would be all taken into account.

Q. All taken into account in what, I'm sorry?

A. Well, in coming to the final list of diagnoses.

Q. I am sorry, you missed the focus of my question, which is, would that material usually be available when the preliminary report is prepared?

A. No, it wouldn't.

Q. No. And after the microscopic and toxic analysis is done and that material available, what was the usual time frame in The Hospital for Sick Children in 1980/81 for the delivery of the typed-up final report?

A. It would usually be in the range



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of, I think two - two months would be a good round figure.

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Q Yes. And I take it - let me ask you this. Is that consistent with the practice of other hospitals with respect to final autopsy reports that are prepared for their own research purposes?

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Q Have you an opinion as to whether at that time your time average was better or worse than normal in Metropolitan Toronto?

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A Well, I don't have experience with Metropolitan Toronto since this is the only hospital I have worked in in Toronto. But it compares very favourably with what I worked in as resident in Seattle and New York.

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Q Yes, all right.

THE COMMISSIONER: You mean compares favourably, I suppose getting it out faster, speed is desirable?

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THE WITNESS: That's what the context ...
THE COMMISSIONER: And Mr. Scott seemed to think so.

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MR. SCOTT: All right.

Q But I take it that in a coroner's



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case the constraints are different and may be imposed
by the coroner to a certain extent?

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A. You mean the time constraints?

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Q Well, for example, if the coroner
assigns your case, I take it he may decide, subject
to your views perhaps, the time parameters in which
he would like to have the work done?

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A. They sometimes ask us to speed a
case up, that's true. But I think the time frame of
two months holds there too.

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Q All right. But I take it in a
coroner's case you're familiar with instances where
the coroner has asked you to speed things up?

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A. Yes.

15

Q And then you do that?

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A. Yes.

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Q If you can?

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A. Yes.

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Q Yes. But I take it a normal
final autopsy report requested by the clinician is in
the nature of a research study?

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A. Sort of, yes.

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Q Yes. Well now, after Dr. Taylor
did the analysis of the Estrella tissues or fluids in
January, we have been told that the readings were



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available I think by early February. Is that
consistent with your understanding.

MR. LAMEK: It's not consistent with
the evidence.

THE COMMISSIONER: No, I don't think so
either. From what Mr. Lamek says that's not the
evidence. I thought it was available in January.
Available, but that doesn't mean that ...

MR. SCOTT: Well, I meant received.

MR. HUNT: I think that Dr. Freedom
indicated that he was told verbally of the results
by the end of January.

THE COMMISSIONER: We can solve that
problem by just looking at the ---

MR. SCOTT: Well, it perhaps doesn't
matter for the purposes of this line of questioning,
Mr. Commissioner.

Q If I can simply ask you this,
Dr. Mancer. Following the receipt of those studies,
did you have a conversation with Dr. Taylor about them?

A No, not after Dr. Taylor's receipt.

Q All right. So, when they were
received I take it it was without any notice to you?

A That's right.

Q Yes. Now, when did you first hear



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about the Estrella readings?

A. At the time we did the checkout of the case, what has been referred to as the sign-out.

Q. Yes. And I think I was absent when you gave that evidence. Did you put a date on that in March?

A. Yes.

THE COMMISSIONER: He referred to the 6th.

THE WITNESS: As best as we could reconstruct out of the events of the 20th to 24th. Dr. Taylor and I thought that it was the period of the 3rd to the 6th of March.

MR. SCOTT: Q. Yes. You may have dealt with this and if you have please tell me, I don't want to bore everybody to death, but did Dr. Taylor describe to you the circumstances under which he had obtained the fluids for assay?

A. Actually, we talked about this this morning. To what extent he described it I can't recall at this point. But I know it's in the last paragraph of my autopsy report.

Q. Yes.

A. And that's the summary of what we discussed.



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Q Well, you may have dealt with this earlier but at that meeting with Dr. Taylor were both he and you of the view that there was a risk that the samples were contaminated?

A Yes.

Q Yes. And I take it that if they were contaminated you were both agreed that they would lose their validity as readings?

A Yes.

THE COMMISSIONER: That's correct, but he also said that when he got the results his main thought was that they were out of line and invalid because of that, there was some error in the calculations.

MR. SCOTT: Q I understand about the calculation, but were you and Dr. Taylor agreed in March that they appeared to be contaminated by virtue of the method by which they had been extracted?

A Yes, we were aware of that.

Q All right. Well, you were aware of the method by which they had been extracted. Were you of the view that that produced a contaminated sample?

A Yes.

Q Yes. And did Dr. Taylor ---



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THE COMMISSIONER: So that there be no misunderstanding. What he said before was that 'It may have entered into my consideration but I was thinking more of an error'.

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MR. SCOTT: Well, I understand that, but I just want to deal with this other matter.

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THE COMMISSIONER: Well, when he answers yes he was, that was the limit he put on it before. If you want to change that now.

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MR. SCOTT: Well, that's why we cross-examined.

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THE COMMISSIONER: All right.

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MR. SCOTT: Maybe I had better go back at it at some length.

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THE COMMISSIONER: All right.

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MR. LAMEK: Would my friend be good enough to identify the samples to which he's referring as having been contaminated.

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MR. SCOTT: Well, first of all, do you recall any discussion with Dr. Taylor in which he described the way the sample or samples in Estrella were taken by him?

22

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THE WITNESS: I can't specifically recall it but we must have discussed it, that's all I can say.

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MR. SCOTT: Q. All right. And I take



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it any information that you had about how that sample
or samples were taken would have come only from Dr.
Taylor?

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A. That's correct.

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Q. Yes, all right. Now, as a result
of having that information communicated to you, did
you draw a conclusion as to whether the sample was
likely contaminated?

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A. Yes, I certainly would have

11

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Q. All right. Was that view shared
by Dr. Taylor insofar as you could tell?

13

A. Yes.

14

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Q. Yes. And was it that basis upon
which the report was signed off?

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A. You mean as the last paragraph -
perhaps I should refresh my memory about the last
paragraph.

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Q. Well, I want you to look at the
report but I also want to get your judgment made
between March 3rd and March 6th as to whether this
sample was contaminated?

22

23

A. Yes, it was certainly my under-
standing that it was contaminated.

24

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Q. All right. And did Dr. Taylor



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appear to share that view from what you could tell?

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A. Yes.

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Q. Now, I take it, stopping right there, that a contaminated sample obtained at or shortly after autopsy can be contaminated high or contaminated low?

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A. That's possible, yes.

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Q. Yes. How can it be contaminated to produce a lower figure than the real figure?

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A. Well, one of the ways that we discussed was the introduction of water which the pathology assistant would use to wash the body and could have leaked in through the incision. Another method would be ---

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Q. Can I just stop you there for a moment. I take it what you mean by that is that if water had been introduced to the sample the reading of 72 might be low because of the dilution factor?

19

A. That's correct.

20

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Q. All right. Are there other ways in which a low reading could be obtained, a lower than real reading?

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A. Yes. If the blood level had been very high and only for a very short time, then



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the digoxin may not have had a chance to equilibrate with the tissue fluids and so the tissue fluids could artificially have lowered the level.

Q. I see. Now, are there ways in which the reading produced could be unrealistically high?

A. Yes.

Q. And would you give an example or examples of that?

A. Fecal contamination could make it unrealistically high because it is my understanding that there is a large amount of digoxin in the feces of patients that are being orally treated with digoxin and I believe also intravenously treated.

So, any fecal contamination could have done it and during the autopsy ---

Q. What is -- I'm sorry, go ahead.

THE COMMISSIONER: You mentioned earlier that there is some splitting of the rectum or something is there not from the autopsy?

THE WITNESS: Yes, that's correct.

THE COMMISSIONER: Automatically which would produce fecal contamination, or give it an opportunity for that?

THE WITNESS: Yes.

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2 diverted - his potential call diverted to that office.

3 Do you remember that?

4 A. Yes.

5 Q. What was the date of that?

6 A. That was the 20th of March.

7 Q. Yes. And Dr. Tepperman
8 wasn't in?

9 A. Well, no. Ordinarily we
10 would contact a specific coroner by calling the
11 coroners office and having them call him and then
12 give the number.

13 Q. I see. In any event he
14 called you when you were in Dr. Ellis' office.

15 A. That's correct.

16 Q. Yes. Did he come over?

17 A. Well, I know that he would
18 have come over after. I don't know whether he came
19 over but when a coroner investigates a case he does
20 come over.

21 Q. Have you any information as
22 to whether Dr. Tepperman came over to Dr. Ellis' office
23 that day?

24 A. No, I don't.

25 Q. Well now, you have said that
you found Dr. Ellis reading the Estrella chart and
the Pacsai chart?



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2 MR. SCOTT: Q. I have it right that
3 having concluded that the sample was contaminated that
4 it would be very difficult if not impossible to
5 determine whether it had been contaminated to produce
6 a higher than real reading or a lower than real
7 reading?

8 A. That's correct.

9 Q. Now, you also told the
10 Commissioner that when you saw the reading, I don't
11 know whether you said this because I was away having
12 lunch this morning but that you thought there was an
13 error in the figure?

14 A. Yes. It was so high, so far
15 beyond the therapeutic or toxic or ordinarily accepted
16 toxic range that it was unacceptable, unbelievable.

17 Q. Unbelievable. Had you ever
18 heard of such a thing?

19 A. No.

20 Q. Now, you deal with these things
21 all the time and, I don't know, can you give me an
22 example of, in normal life, of a figure produced
23 that is so unbelievable that the mind rejects it?

24 A. Well, I was trying to think of
25 an analogy.

Q. Because I asked you to, weren't
you.



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2 A. Yes, I guess we have all
3 bought cars and we have been interested in miles per
4 gallon that they get and if we were told by somebody
5 that there was a new car out that could keep up with
6 any car on the road and carry a normal sized family
7 and it would get 200 miles to the gallon we simply
8 wouldn't believe it, we would expect more like 15
9 miles to the gallon from such a car at best.

10 THE COMMISSIONER: And if you were
11 to say that we could get a witness in and out of the
12 witness box in half an hour you wouldn't believe that
13 either.

14 MR. SCOTT: Q. Well, I take it that
15 each of us had our orders of incredulity. The
16 Commissioners are well known and clearly established,
17 we don't have to dwell on them further but I take it
18 that is an example of the same level of credulity
19 as far as you are concerned?

20 A. Yes, I think that's the way
21 a doctor would look at these figures.

22 Q. And I take it that when you
23 had finished reviewing and reported out the Estrella
24 would it be fair to say that there was no cause for
25 concern in connection of anything you then knew
about Estrella, the Baby Estrella?



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A. At the time of the report,
yes.

Q. Yes.

A. I thought that there was ---

Q. And as Mr. Lamek has said
it is only when the Pacsai reading comes to light
that you think of Estrella again?

A. Yes. I should add to that
last question though that we did append the last
paragraph with a sentence giving a reservation about
the reading and that if those figures were accurate
that that could explain the cause of death. But I
certainly, I wasn't convinced that that digoxin level
of 72 nanograms per millilitre was valid.

Q. Well, let me test you this
way. You say you weren't convinced that it was
valid. Would it be fair to say that you were
convinced that it wasn't valid?

A. Yes, but I still felt
obligated to say something in the report about it.

Q. I understand that. Now,
you have told us about a number of meetings, the
first to which I want to draw your attention was
the meeting when you went down to Dr. Ellis' office
after you had called Dr. Tepperman and had the calls

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A. Well, I know he had the Estrella chart in his office at that time.

Q. All right, that's the one I wanted to talk about.

A. Yes.

Q. Did he have on that chart or with him your final autopsy report?

A. I can't recall specifically but I'm sure it would have been there.

Q. All right. Now, why do you say you are sure it would have been there?

A. Well, at that time the autopsy reports were being distributed through medical records to the charts and the doctors. We used to send our reports to records who would then put a copy on the chart and also send them to all the doctors that were appropriate to receive them.

Q. All right. Now, if Dr. Tepperman came to Dr. Ellis' office that day and was shown the Estrella record is there any reason to believe that he would not have seen your final autopsy report, of which you are aware?

A. I don't think there is any reason to believe that he would not have seen it.

Q. All right. And if he had



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(Scott)

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seen it I take it he would have seen your remarks
about contamination?

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A. I would think so, yes.

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Q. Was there a meeting on March 24th which was attended by representatives of the hospital, the coroner's office and detectives?

A. Yes.

Q. Did you attend?

A. Yes.

Q. Do you recall which coroner was there?

A. Dr. Ross Bennett I know was there.

THE COMMISSIONER: Dr. Ross Bennett?

THE WITNESS: Yes, sir. I cannot recall if there were any others.

MR. SCOTT: Q. Would you have known at that time the names of the detectives who were at that meeting?

A. I do know. I believe that - I think I knew Sergeant Warr at that time and Staff Sergeant Press were there.

Q. Were they at that meeting?

A. I believe so.

Q. Was there a discussion of Estrella at that meeting?

A. Yes.

Q. Was there any discussion about



1
2 the contamination of the Estrella sample?

3 A. Yes, I believe there was.

4 Q. Can you tell the Commission how
5 that arose as best you can remember it?

6 A. I know I was asked about whether
7 contamination would have artificially raised or
8 lowered the level and I did give an answer.

9 Q. Was that in connection with
10 Estrella?

11 A. Yes.

12 THE COMMISSIONER: Raise and lower, and
13 you gave the answer. Would you mind telling us just
14 what answer you gave?

15 THE WITNESS: All right. I believe I
16 said at that time that it would artificially lower the
17 level but that was in a certain context.

18 MR. SCOTT: Q. What context?

19 A. I had been thinking about these
20 cases that we had been having over the weekend and that
21 was after the Miller and Cook deaths which my colleague
22 autopsied. I knew about the level in the Pacsai case
23 and I knew about the high level in the Estrella case
24 and I thought there was something unusual related to
25 high levels of digoxin going on in the hospital. I
had formed a possible opinion as to how it could have



1
2 been done.

3 Q. And did you disclose that
4 opinion?

5 A. Well, my idea was that the most
6 likely thing that would have happened was that a large
7 intravenous dose could have been given to each of the
8 patients and if that had been the case --

9 Q. Was this something you were
10 thinking of over the weekend?

11 A. Well, probably - Tuesday rather
12 than over the weekend - Monday and Tuesday, likely.

13 Q. And if that had been the case,
14 what?

15 A. If that had been the case and
16 the patient died as a result of a large intravenous
17 dose it is not likely that the level in the blood
18 would have equilibrated with the tissue fluid so the
19 tissue fluid would have been lower and that would have
20 artificially - the presence of tissue fluid in the
21 sample would have artificially lowered a higher
22 reading and Estrella could have had a higher than 72
23 nanograms.

24 Q. Did you discuss that?

25 A. I am not sure in what depth we
discussed it but I believe I brought that possibility



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2 out, that dilution is a likely result of contamination.
3 I did not know as much about digoxin then as I do now,
4 and I would alter my opinion at this point.

5 Q. How would you alter your opinion?

6 A. There are a lot of other factors.
7 I did not know about the high fecal levels of digoxin
8 in a patient that has been treated with digoxin as
9 Estrella was. I also did not know, at least I don't
10 think I knew - I knew about the heart level being high
11 but I am not sure that I knew about the skeletal muscle
12 levels being high and there certainly could have been
13 contamination from tissue fluid around the skeletal
14 muscles so this would have artificially raised the
15 level.

16 Q. Do you recall who raised the
17 question of contamination of the Estrella sample on
18 that date?

19 A. No.

20 Q. Can you tell us how long that
21 question of contamination in the Estrella sample was
22 discussed, approximately?

23 A. I think it was only a very brief
24 part of the --

25 Q. What does that mean?

A. Probably a minute or so.



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THE COMMISSIONER: A minute, did you
say?

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THE WITNESS: A minute or so, maybe
even less.

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MR. SCOTT: Q. How many people talked
about it?

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A. I cannot recall.

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Q. You see, Dr. Mancer, the point I
want to get at is that there may be an issue as to
whether the issue of contaminated blood in Estrella
was discussed on March 24th - do I have the right
date? - yes.

13

MR. LAMEK: That should be raised in
the second phase.

14

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MR. SCOTT: Well, it has been raised
in this phase of the Inquiry. Yes, it has.

16

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MR. LAMEK: No, it was March 21st that
we talked about.

18

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MR. SCOTT: Well, if you don't want me
to deal with it --

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THE COMMISSIONER: Don't trap me that
way. You can deal with it if you like.

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MR. SCOTT: All right.

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THE COMMISSIONER: But I ask you not to
deal with it if you do not think it is relevant to



1
2 this phase. If you think it is relevant to this phase,
3 then by all means, do. One of the problems is that we
4 don't want to have to call back Dr. Mancer just for
5 that question. I suppose he is part of the second
6 phase too, is he?

7 MR. LAMEK: I suspect he may be. I
8 think he will be or we are going to get into this
9 terrible double --

10 MR. SCOTT: I think he will be back
11 and I will therefore defer any evidence on that
12 subject.

13 Q. Let me come to this list that
14 you prepared.

15 First of all, let us take Exhibit 197
16 first. Have you got that in front of you?

17 A. Yes.

18 Q. You don't recognize that hand-
19 writing, or do you?

20 A. I don't recognize it.

21 Q. And you are not able to tell the
22 Commission Counsel who gave you that. Are you able
23 to exclude anybody, for example, can you tell us
24 whether you obtained that from someone on the staff
25 of the hospital or from someone outside the hospital?

A. When the subject of how we drew



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up the table, Exhibit 198, first came up about a few weeks ago, we found in Dr. Phillips' files this list which is Exhibit 197 and it is fairly obvious to me that it is the list from which we made the table, Exhibit 198.

Q. We are all with you there.

A. I know we made the table on the period of the 24th/25th, finishing it at about 10 o'clock on the 25th.

THE COMMISSIONER: That is 10:00 p.m. or 10:00 a.m.?

THE WITNESS: 10:00 a.m. So I assume that we received the list at the meeting on the 24th or some time shortly after.

MR. SCOTT: Q. Can you come now to my question? Are you able to tell us whether you received it from someone on the staff at the hospital or from someone outside the hospital? If the answer is you do not know, just say so.

A. We tried medical records as a possibility because they have - on this list there are some cases that never would have come through our department as there was no autopsy consent and no autopsy done - Fazio, Manojlovich and Gionas.

Q. So three of those babies were not



1
2 autopsied?

3 A. That is right.

4 Q. So the list would not have been
5 generated, I take it, by someone who was looking only at
6 babies autopsied?

7 A. That is right.

8 Q. All right.

9 A. We thought of possibly medical
10 records and we showed the list to the chief librarian
11 of medical records and she checked with all her people
12 on it. It was nobody's handwriting in medical records.
13 We did not check with the cardiology people who
14 possibly could have generated the list. We thought
15 it probably came from the police.

16 Q. The list, I can tell you, is a
17 list of the babies who died in wards 4A or 4B after
18 January 11, 1981, with two exceptions. I want to ask
19 if you know anything about why two babies were
20 excepted from what looks like a chronological list?

21 A. I don't know.

22 Q. In any event, you obtained the
23 list and I take it you then started to make up the
24 sheet which is Exhibit 198?

25 A. Well, first of all our main aim
was to finish the reports on all of the patients on



1
2 the list 197, and we thought it would also be helpful
3 to the conference to be held on the next morning, which
4 was already called for 10 o'clock, if we had a table
5 through which we could discuss what tissues were
6 available and specimens were available.

7 Q. And this was the table?

8 A. Yes.

9 Q. I take it that what you have in
10 front of you is a photostat of the original?

11 THE COMMISSIONER: Sorry - the two
12 exceptions - I just was curious to know?

13 MR. SCOTT: You want the names -
14 Floryn, who died on February 8, and Leith who died on
15 the 6th of March and there is also left off - sorry,
16 that is it.

17 MR. SHINEHOFT: Mr. Commissioner, is my
18 friend referring to the exceptions as being as to the
19 place of death of these patients?

20 THE COMMISSIONER: He said the ones on
21 the ward - when you say that those are the only ones,
22 I guess you are right, Floryn and Leith.

23 MR. SHINEHOFT: It is my understanding,
24 Mr. Commissioner, that Pacsai died in ICU.

25 MR. SCOTT: That may be so but Floryn
died in 4B and Leith died in 4A, according to my



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information.

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Q. What you have in front of you,

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I take it, is a photocopy of the original list you
made?

5

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A. Yes.

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Q. And the original list, I have it
from you, was made in pencil?

8

A. That is correct.

9

10

Q. When it was made, can you tell me
who was present?

11

12

A. I think it was made over the
period the 24th/25th from the end of the meeting on
the 24th which would have been about 11:00 a.m. until
10:00 a.m. on the 25th when the meeting was to start.

13

14

Q. Who did the original pencil
writing on this sheet?

15

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A. The table was drawn out by me.
The headings were written by me. That is my printing.
Then Dr. Cutz and I filled in the data. Obviously the
first three columns are copies of Exhibit 197.

18

19

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Q. So would it be correct that if
we had the pencilled sheet in front of us now we would
see only the writing of you and Dr. Cutz?

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22

A. I believe that is so, yes.

23

24

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Q. And I take it Dr. Phillips was



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away?

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A. That is correct.

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Q. Where was he?

5

A. He was on vacation I believe in
Virginia but I am not sure.

6

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Q. Do I have it that in preparing
this pencil form you took, first of all, the cases
in which you had been the pathologist?

8

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A. I believe that Dr. Cutz and I
filled in data on our own cases plus Dr. Phillips'
cases that each of us had signed out, and Dr. Becker's
cases as well.

13

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Q. What I am trying to get at is
that the diagnosis, as you have told Mr. Lamek, was
a relatively straightforward matter of copying out
what appeared in the final autopsy report that you had
just then completed, in some cases?

17

A. Yes.

18

19

20

Q. Now when you come to cause of
death, who made the judgment in any individual case
as to what went under the heading "cause of death"?

21

A. I believe it was Dr. Cutz or
myself.

22

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Q. How would you divide up the
cases in order to make that judgment, or was it a joint



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judgment in each case?

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A. I cannot recall whether it was joint or whether we did it on the basis of me doing my cases and he doing his cases. I am not sure how we divided up Dr. Becker's cases. We did divide up Dr. Phillips' cases though for the purposes of sign-out.

Q. Now when you looked at Dr. Becker's cases and Dr. Phillips' cases, neither of them were present?

A. I believe that is true. Certainly Dr. Phillips was not present.

Q. And therefore your assessment of cause of death was what you were able to draw from the final autopsy report which they had made?

A. Yes, plus knowledge of the digoxin levels in Pacsai and Estrella and Miller and the strong suspicion on Dr. Cutz's part that the Cook baby fell in the same category.

Q. It is a matter of some importance, so I want to go at it. When you came to Estrella, that was a report that you had signed out?

A. Yes.

Q. And the diagnosis was simply copied from the form?



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A. Yes.

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Q. The digoxin overdose was

4

obviously not copied from the form because you had

5

made a point about what your final autopsy report had

6

to say about that?

7

A. Yes.

8

Q. Why did you put digoxin overdose

9

in on March 24th or thereabouts when you had given a

10

final autopsy report three weeks before that said

something different?

11

A. Well, now there was new

12

information.

13

Q. What was the new information?

14

A. That there were cases of babies

that had very high digoxin levels in their blood.

15

Q. And you are referring to Pacsai,

16

Miller and Cook?

17

A. No, Pacsai, Estrella and Miller.

18

Cook was not available at that point but there was a

19

suspicion already about it.

20

Q. Let us talk about Estrella. In

21

your autopsy report you described the contaminated

22

sample and you have told us that you formed a judgment

about its contamination.

23

When you came to prepare this, there

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EE 14

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were two deaths, Pacsai and Miller, in which there
were elevated digoxin readings. Right?

A. Yes.

Q. You knew of those when you filled
in this form, Exhibit 198?

A. Yes.

Q. Was there any new information on
the subject of Estrella?

A. Nothing new in that particular
case.

Q. Anything new at all on
Estrella?

A. Not on Estrella itself.

Q. Was there anything new on Fazio?

A. No.

Q. Or Thomas or Warner or Hines or
Gionas?

A. Nothing new, no.

Q. Or Manojlovich or Inwood or
Gardner?

A. No.

Q. So I take it when you put in
under cause of death digoxin overdose or natural or
undetermined or probably natural you were reflecting
not new information on those cases but what you



EE 15

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believed to be so about Pacsai and Miller?

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A. Yes, that is correct.

4

Q. That is all?

5

A. Yes.

6

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Q. I put it to you, Doctor, that this was believed by you at the time, from whomever you obtained it, to be a list of the candidates or the suspects in a murder case?

9

A. Yes.

10

THE COMMISSIONER: A list of the victims, surely?

11

12

MR. SCOTT: Victims, I am sorry, quite right. I am not used to murder cases - but the list of victims in a murder case.

13

14

THE WITNESS: Yes, I believe the subject of murder had already come up at that point.

15

16

MR. SCOTT: Those are all the questions I have.

17

18

THE COMMISSIONER: All right, thank you. Miss Chown?

19

20

MR. SCOTT: Could I ask one other thing?

21

THE COMMISSIONER: Yes.

22

23

MR. SCOTT: Q. You told Mr. Lamek about Exhibit 202A and 202B. This was the protocol and the amended protocol that you prepared in order

24

25



EE 16

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I gather to facilitate a study of contamination samples.

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Is that how you understood it to be?

4

A. Yes, we were trying to duplicate

5

the Estrella case as closely as possible.

6

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Q. Who was to do the duplication?

A. Well, the pathologist that were supervising each of the autopsies were to make sure that the samples were taken in the way indicated.

Q. I understand that, that the protocol and the revised protocol were a check list as to how in the order in which the samples were to be taken?

A. Yes.

Q. Who was going to do the attempt to duplicate the Estrella readings?

THE COMMISSIONER: Nobody is doing it, unless I am misunderstanding, nobody was going to do it on Estrella, this is on other.

THE WITNESS: What we were trying to do was duplicate a situation under which the Estrella samples were obtained.

Q. For what purpose?

A. To see if any of these factors, such as contamination by feces and contamination by fluid from the leaking from the muscles around the abdomen could alter what was in the blood for a patient who was on digoxin.

Q. And in short form, you would take; number one, the best kind of sample



1
2 possible; and then you would get down to the milking
3 of the blood, and you would compare them?

4 A. Yes.

5 Q. Now, who did that, who made
6 comparisons?

7 A. All the data was sent back
8 to Phillips.

9 Q. And do you know if Dr.
10 Phillips analysed it?

11 A. Yes, it has all been
12 tabulated.

13 Q. Have you seen his report?

14 A. I haven't seen it, no.
15 All I have seen, I have seen parts that Mr. Lamek
16 showed me but I haven't really been privy to all the
17 information.

18 Q. Have you got copies of that?

19 MR. LAMEK: Some of it.

20 MR. OLAF: Ask the witness,
21 perhaps, does he know what the results are.

22 MR. LAMEK: Had I any indication
23 that Dr. Mancer would have told me I would have
24 asked him, I promise you, but we will be calling
25 Dr. Phillips.

THE COMMISSIONER: You can do that or



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not, but Mr. Olah will have to sleep on that problem
until tomorrow.

3

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MR. OLAH: I'm not sure I can,
Mr. Commissioner.

5

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THE COMMISSIONER: Well, Miss Chown.

7

MS. CHOWN: Thank you, Mr. Commissioner.

CROSS-EXAMINATION BY MS. CHOWN:

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11

Q. Dr. Mancer, we know that Dr.
Taylor performed the Estrella autopsy on January
the 14th, and you have told us that you were the
supervisor of him with respect to that autopsy?

12

A. That is correct.

13

Q. Did you also indicate ---

14

MR. LAMEK: I believe it was
January the 11th.

15

MS. CHOWN: I am sorry.

16

17

MR. LAMEK: I think January the
11th was the date of the autopsy, the date of the
autopsy report.

18

19

Q. Yes, January 11th. Now
you also told us this morning that it might have
been the first autopsy that he had done at the
Hospital for Sick Children.

20

21

22

A. Yes.

23

Q. And I think you also told

24

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us he was at the same time quite experienced and
had done other autopsies?

4

A. Yes.

5

6

Q. Can you just assist us by
explaining why this might have been his first
autopsy at the Hospital for Sick Children?

7

8

9

10

A. Well residents normally
change rotation, they rotate from one hospital to
another, on January 1st and July 1st, and Dr. Taylor
had come to us as of January the 1st.

11

12

13

Q. And therefore this might
be his first one that he was available for that he
had done?

14

A. Yes.

15

16

Q. But your lack of hesitation
of having him complete the autopsy was because of
your knowledge of his prior experience?

17

A. Yes.

18

19

20

Q. Also you told us the first
time that you and Dr. Taylor had a discussion about
digoxin levels was not until March when you were
signing out the Estrella autopsy report?

21

A. That is correct.

22

23

Q. I think you were asked this
morning if you could recall if you had had any

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discussion prior to that point with Dr. Taylor about
that issue, and your answer was that you could not?

4

A. That is correct.

5

Q. And did you subsequently

6

become aware that he had had some discussions with
Dr. Freedom on this topic?

7

A. Yes. He told me that he

8

had met Dr. Freedom to discuss it.

9

Q. Can you assist us today as

10

to why he would not have brought it to your attention
prior to March the 3rd?

11

A. Well I think that he

12

appropriately got back to the individual who had
asked him to do the test in the first place and he
reported back to him and just discussed it with
him.

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MS. CHOWN: Thank you. Those are

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my questions.

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THE COMMISSIONER: Thank you.

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I guess we will recess now.

4

Well, we won't recess. I just
want to discuss with you -- Doctor, you are due
tomorrow at ten o'clock.

5

6

--- witness withdraws.

7

8

THE COMMISSIONER: I just want to
say a word about, or hear a word about the summaries.

9

Does anyone have any views?

10

Yes, what do you have to say,

11

Mr. Young?

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MR. YOUNG: Mr. Commissioner, we
examined the summary and, indeed, it appears to
have been done in a very professional manner and it
is quite complete. I don't know that we can
promise that we would use or ask for this summary.
I am trying to keep notes - I would not be bold
enough to call it a summary but if, indeed, we
needed more information, we would utilize the daily
transcripts, plus I don't think we would have any
use for that particular summary.

20

THE COMMISSIONER: All right.

21

Yes, Mr. Olah?

22

23

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MR. OLAH: To assist you, I have
canvassed virtually every other counsel, except
for Mr. Scott, and I have been advised that every-
one finds the summaries helpful and want to have



1 them. I think Mr. Hunt, on his part, wanted to
2 say he might consider paying a nominal fee, the
3 fee you have suggested, to acquire it.

4 THE COMMISSIONER: What does he
5 consider a nominal fee? 25 cents?

6 MR. HUNT: A page.

7 THE COMMISSIONER: Pardon?

8 MR. HUNT: A page.

9 THE COMMISSIONER: A page.

10 MR. OLAH: I think you said \$25.

11 THE COMMISSIONER: I suggested
12 \$25; I don't think that it was that outrageous.

13 MR. HUNT: That doesn't sound
14 outrageous.

15 THE COMMISSIONER: No.

16 Does anyone else have any thoughts
17 on it?

18 MR. LAMEK: Mr. Commissioner, just
19 before you get overcome by generosity --

20 THE COMMISSIONER: We may have to
21 charge more.

22 MR. LAMEK: What you proposed,
23 the \$25, what has been seen, I think, is a summary
24 of several volumes.

25 THE COMMISSIONER: Oh yes, it is
 \$25 a day. Because it is going to cost us -- can I



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2 reveal what it is going to cost us?

3

MR. LAMEK: Why don't you.

4

THE COMMISSIONER: I think it is
5 going to cost us \$150 a day, but there are only --
6 I don't know how many - there are only one, two,
7 three.

7

MR. YOUNG: I believe there are
8 four, Mr. Commissioner.

9

THE COMMISSIONER: Pardon?

10

MR. YOUNG: I believe there are
11 four; the Hospital, the doctors, the Attorney General
12 and our office are the only unfunded counsel.

12

THE COMMISSIONER: Yes, all right.

13

I think there is no reason why
14 the Commission shouldn't pay something for it. At
15 any rate, you don't want it, Mr. Young?

16

You do want it, is that it?

17

MR. HUNT: Yes.

18

THE COMMISSIONER: Miss Chown,
19 do you want it?

19

MS. CHOWN: I am in Mr. Young's
20 position. We appreciate the care with which it has
21 been done but --

22

THE COMMISSIONER: You don't want
23 it either?

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MS. CHOWN: No.

THE COMMISSIONER: Mr. Scott?

MR. SCOTT: Well, I'm not sure that I know what we are talking about.

When we discussed it, I think we decided that the price was reasonable and, while we don't want it to be exclusive in any sense, we wouldn't object to paying it.

THE COMMISSIONER: You wouldn't object to paying it.

MR. SCOTT: Yes.

THE COMMISSIONER: Do I understand, Mr. Olah, that you are speaking for everybody else, are you?

MR. OLAH: I believe I have canvassed everybody.

THE COMMISSIONER: Of course, they are much more enthusiastic because it is not suggested that they pay. The principle, though, before you vote in favour it, the theory behind it will save you some time that might be reflected in the bills.

MR. SCOTT: You don't care whether I buy it, then? I take it that is for funded counsel?



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2 THE COMMISSIONER: Well, that is
3 one of the things. Yes, I do care if you buy it
4 because that will make it less expensive for us if
5 you buy it. I really don't know whether this is
6 going to save money for the Commission or not, because
7 if we are going to put out \$150, as it looks at the
8 moment, we will get \$50 of that back if we do it.
9 But that \$50, that \$100 we are paying out, I was
10 hoping would be reflected in an advantage to the
11 funded counsel who would find it of considerable
12 help to them in reducing the time that they are
13 going to otherwise spend, that's all. It is
14 really a financial enterprise.

15 MR. SCOTT: We will participate.

16 THE COMMISSIONER: Mr. Tobias?

17 MR. TOBIAS: Yes, Mr. Commissioner.

18 I, as well, have reviewed the
19 document last night and found it very well done and
20 it probably would be helpful, subject only to this
21 caveat; that the savings in terms of time will be
22 accomplished, I have no doubt about that, but the
23 savings - because the most handy way to use the
24 document is sort of as an index to the daily tran-
25 script.

THE COMMISSIONER: Well, I would



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2 think that if, being realistic about it, you can
3 use it a great deal more than as an index. If you
4 are just going to read that document and read the
5 transcript as well, we can forget about the whole
6 thing.

7 MR. TOBIAS: That document would assist
8 me personally in acquiring the reference in the
9 transcript that I wanted, but I will probably still
10 read the transcript and not rely solely on the
11 summary.

12 THE COMMISSIONER: Are you going
13 to read all of the transcript as well as the summary?

14 MR. TOBIAS: No, no.

15 THE COMMISSIONER: If that is so,
16 then it is a waste of time.

17 MR. TOBIAS: I am not going to
18 read all of the transcript and I haven't been reading
19 all of the transcript. I think that would be an
20 impossible task. But what I am saying is those
21 portions of the transcript --

22 THE COMMISSIONER: Yes, I under-
23 stand that, I understand that. I can fully under-
24 stand that problem, but this isn't going to be an
25 enterprise that is worthwhile at all if everybody
is going to sit down and read the transcript and read



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the summary as well.

MR. TOBIAS: I agree, and that is why I am raising the concern.

THE COMMISSIONER: Would it not -- are you telling me that it would not save you any time?

MR. TOBIAS: I don't think it would save me any substantial time because, in my own mind, I would still want to read the transcript.

THE COMMISSIONER: It is probably not worth having.

Does anyone else feel the same way?

MR. BROWN: Well, Mr. Commissioner, it would save us time, approximately an hour to an hour and a half a day because we summarize the transcript in due course anyway. We have used Mr. Olah's transcripts before and they are very good and very reliable and, so, we would rely on those and it would be a saving of time.

The concern that I would have is that there is some rapid turnover between the day of the hearing and the date of the summary, somewhere in the neighbourhood of three to four days.

THE COMMISSIONER: Yes.

MR. BROWN: If they can be produced



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in that time, then it would be a saving.

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THE COMMISSIONER: Certainly

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they can be, but remember, it is not just for that;

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it is a permanent record that we might have that,

6

even when it comes to argument and something else,

7

we might make it of some use.

8

Yes, Miss McIntyre.

9

MS. MCINTYRE: We have had some

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experience already with summaries and find that

11

they are very useful and that our feeling is that

12

it would save a substantial amount of time in that

13

they read much more quickly than the transcript.

14

THE COMMISSIONER: I haven't

thought this out, but you might find yourself having

15

to pay half of the tariff.

16

MS. MCINTYRE: Well, in that case --

17

THE COMMISSIONER: Well, I don't

know. I will think about it.

18

Does anybody else have any

19

comments?

20

All right. We'll order it and

21

everybody will be bound by an oath in blood not to

22

reveal one solitary word to either Mr. Young or

23

to Miss Chown what is in them, that's all!

24

Unitl ten o'clock tomorrow morning.

25

--- whereupon the hearing was adjourned until
Wednesday, the 28th day of September 1983, at
10:00 a.m.

